Examiner Box 68760. P.0. Records, Division of Vital

be executed burial-tran and physician the attending ph for use as th signed by the a d be detached for icate has been significate has been significated by page 2 should by certificate has Hospital or Attending Physician: director, After this funeral death. within 24 hours after death To the Funeral Director: filled in by the completely

Physician

Examiner

Funeral

Director

28a-f show

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Hygiene.

12 should be filed with and Mental Hygier 7 is marked other the

permit. Pages 1 and 2.
Department of Health & Important: If item 27 is any injury or other trausonce.

Physician

/Medical

Saltimore, Maryland 21215-0036

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Certification: To

Medical

traumatic event, the Medical Examiner must be notified at

/Medical

thromboe 25. Was case referred to medical 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and t le of certifier

29c. License number D002246 29d. Date signed (Month, Day, Year) Kehruny 9, 2009

30. Name and address of person who com d cause of death (Item 23a) (Type, Print)

Or. Glan Burnu, MD 2106 STUDIT lacubs mo 305 Nospital

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

Certificate of Death

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Funeral Director

death with the Maryland and 2 should be filed within 72 hours after death with the Marylan eath and Mental Hyglene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any Injury or other trau Physician /Medical Examiner The law requires that the death certificate be executed and burial-tra Division or Vital Records, P.O. Box 68760, physician the as use signed by the detact 2 should certificate has page funeral director or Attending nours after death.

neral Director: / within 24 hours at To the Funeral C Hospital

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4:50 P^{M} 29, 2009 Ruth S. Bradford January 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Hyattsville 3714 Jefferson Street 8. Date of Birth (Month, Day, Year)
April 12, 1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Beallsville, PA 1 □ M 2 🗓 F 173-12-6623 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Directo Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code 20782 USA 3714 Jefferson Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Vance Torrence M. Patton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3714 Jefferson Street, Hyattsville, MD 20782 Wallace Bradford / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/2009 Brentwood, Maryland Fort Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Stenosis disease or condition resulting in death) Due to (or as a consequence of): Hypertension 30 Years Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Neuropathy autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of celtifier

31. Date filed (Month, Day,

FEB 0 2 2009

Adolph W. Johnson, Jr.,

Year)

30. Name and address of Person who completed caust of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D33109

12520 Prosperity Drive, #150, Silver Spring, MD 20904

State of Maryland / Department of Health and Mental Hygiene, 05003 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wanda Olea Beall Month Year /Medical January 2009 3:40 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 578-48-5109 1 □ M 2 🛛 F Months Days Hours Min Director February 9, 1937 Washington, Usual Residence of Decedent 10a. State show 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examinat must be notified at 10d. Inside City Limits Director Maryland Frederick Walkersville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Adams Court 21793 USA Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or i If Yes, Give Year or Dates ģ 1 ☐ Yes 2 🖾 No Specify. 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other transmet. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Lee Hazel Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Johnson / Daughter 6516 Roy Shafer Road, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2/4/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Sayl RAY Rayens Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final disease or condition resulting in death) **Physician** Onset and Death FWOY COMA 10 YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 C Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Month 1 ☐ Yes 2 No Day Year this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 🖼 Natural 5 Pending death. 2 Accident investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Dire 4 Homicide 24 hours within 24 hou To the Fune completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 TAVRY AVR # 204, FRANKLIK, MD 21702 WO . 31. Date filed (Month, Day, Year) FEB 0 2 2009 32. Registar's Signature State Registrar

DHMH 17 Rev 1/2001

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than '

Department of H Important: If ite

or other

Injury

any

Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No P 27. Manner of Death Certification; 12 Natural 2 Accident 3 ☐ Suicide in 24 hours
the Funeral Dires.
To filled in by 4 ☐ Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22305 am 30,09 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BRANCH AVE. SUITE 407 , TEMPLE HILLS, MD 20748 MASSOUD NEMATI 3611 DR. 31. Date filed (Month, Day, Year State FEB 0 4 2009 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** OZ PM Banks 31 Jan 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner er 6. Sex B. 117 A C T.
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) University Medical Center 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 73 213-30-3807 March 12,1935 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20032 1801 Valley Terrace, S. E. United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? **Feb.1954** 1**X**Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ayes 1 and 2 should be filed within 72 hours after can of Health and Mental Hygiene.

t: If item 27 is marked other than "natural" or linering or other traumation. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Jan. 1958 2 **Black** Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. General Services Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor 12th grade Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental George Kinsey Banks, Sr. ပ Mary L. Charity 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Marie Adams Banks, (Wife) 1801 Valley Terrace, S.E.; Washington, D.C. 20032 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department t Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Quantico National Cemetery Quantico, Virginia 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Puneral Service Ligar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bacteremia 4 days /Medical Due to (or as a consequence of): Examiner Fungemia Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Anoxic Brain and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical Seizure 4 days the as 1 IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.0. 1 □Yes 2 □No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Disease Remal 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 **N**O 1 ☐ Yes 2 ☐ No 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division or Attending Natural 5 ☐ Pending investigation r death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital within 24 hours a To the Funeral C

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Registr ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month. Dav. Year)

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Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9 1 - For State Registrar 05006 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 30, 2009 Year Bermudez 1431 Maria 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 48 Months Days Hours Min. *\$117251*17960 E1 cougal vador 215-29-7660 Usual Residence of Decedent 10c. City, Town or Location Rockville 10d. Inside City Limits 10b. County 10a. State Montgomery 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 El Salvador 4812 Boiling Brook Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ¹^ĭAYes ^{2□No}El^{Specify}älvadoren White 3 ☐ Widowed 4 🕇 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Maintenance 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Bermudez Tiburcio Rivas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zic Code) Md20852 4812 Boiling Brook Parkway Rockville, Md20852 19a. Informant's Name/Relationship (Type. Print) Jose Bermudez/Son Date 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation Silver Spring, Md 2/3/2009 Gate of Heaven 4 Donation **4**5 ☐ Other (Specify) PATTED ADDITION ADDITIONAL DI FUNERAL SERVICE, P. A 21. Signature of 9241 Columbia Blvd Silver Spring, Md20910 23a. Part 1. En or the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aneurysmal cerebral rupture disease or condition resulting in death) Due to (or as a consequence of): Delayed cerebral vasospasm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

/Medical Examiner ending physician and use as the burial-tran attending properties for use as signed by the a To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has by to To the Funeral Directors to the form or ompletely filled in by the funeral director, page 2 sh

Box 68760.

P.O.

Records,

Vital of

Division

Physician

Physician

/Medical

Examiner

MD

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Funeral

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, Ire Medical Exeminar must be notified at

Baltimore, Maryland 21215-0036

Pages .

Examine **dedical**

Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?	26. Place of Death (Cl	Check only one)
70 E	1 Yes 2 No	Hospital: 1₺ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred
Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier (Check only one) Certifying Pl Certifying Pl Medical Example:	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

D0057862

Auburn Ave. Bethesda, Md

29d. Date signed (Month, Day, Year)

Feb. 1, 2009

20814

State Registrar 29b. Signature and Itle of certifier

31. Date filed (Month, Day,

Rocco Armanda MD

FER U4

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4927

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar/MFND#31see#32,2-4-09,BWW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Edward Beall Lawrence 2009 10:40 a^M February l, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year) Months Days Hours MXM 2 1929 Washington, 223-36-5503 79 Dec. 16, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Tyes 2 XXX Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 3708 Leverton Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married ★★ Married 1 □Yes 2√EXNo If Yes, Give Year or Dates: 1954–61 Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>Mechanical Engineer</u> Heating/AC Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert McFarland Beall Marie Barbara Diamond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sheila Beall/Wife 3708 Leverton Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 5 500 University Blvd., W,. Silver Spring, MD 20901 any CC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the shock, or heart failure. List only one cause on each line. h as cardiac or respiratory arrest. Immediate Cause (Final 70 disease or condition resulting in death) Due to (or as a consequence of): easl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MC Due to (or as a consequence f): Due to (of as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show

death

and 2 should be filed within 72 hours after of the and Mental Hygiene.

Pages 1

of Health and Mental Hygiene.

other traumatic

Department of H Important: If ite any Injury or ot 2000e.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical <u>۾</u> Completed certificate Be ို To the HospitaNot Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this

Hospitabor Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Certification: 1 Natural 2 Accident

IF FEMALE

24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 No

examiner? 1 Yes 2 No
27. Manner of Death

3 ☐ Suicide

29a, Certifier

30. Name

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature

and address of person

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signature FEB 04

who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:10 PM MARGARET LOUISE BAKER February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🗓 F 325-14-5907 Yrs. Director Jan. 25,1918 Illinois Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examiner past be notified at Director MD 1 ☐ Yes 2 🛛 No Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 16925 Briardale Road Funeral 20855 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Lisiecki Mary Szyperski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Georgia L. Parker (Daughter) 16925 Briardale Rd. Rockville, MD 20855 other 20a. Method of Disposition Department of H
Important: If iter
any Injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Seymour, IN 4 ☐ Donation 5 ☐ Other (Specify) 2009 Riverview Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardio Pulmonary Arrest /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Due to (or as a consequence of) law requires that the death certificate be executed Exami Coronary Artery Disease and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending photon for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🏋 No 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.O. the detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş icate has been sit, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No The certificate 1 ☐ Yes 1 ☐Yes 2 ☐No the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No After this of funeral direction 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation ה Hospina בי n 24 hours after death. the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2. è 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0067512 February 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Madan Bangalore M.D. 9901 Medical Center Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FER 04 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2/10/09 M.S. Kent Co. Department of Health and Mental Hygiene Reg. No. 2 0 1 - For State Registrar Amended#2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 15AM OSIELLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 22-12-5042 1 ☐ M 2 🔀 F 8 6 1922 Director ND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Heen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 2/6 Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: UES Specify: Black 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory, or other place) (Daughter Oan illington, MD 20a. Method of Disposition 20c. Lecation - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State raves 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Name and Address of Facility Bennie East Dover St Pan Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Priset and Death EIMER Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 1 🗌 Yes 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to redical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and tile of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Death	Reg. No. 2009 050						
Physician/ ledical Examine	Morgan Jane Elizabeth	Beverly	2. Date of Death Month Day Year January 25, 2009 3. Time of Death 0841 hrs						
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Dea	4c. County of Death Anne Arundel						
Funeral Director	213-37-5242 1 M 2 X F	$\begin{array}{c cccc} (In \ yrs. \ last \ birthday) & If \ Under \ 1 \ Year & If \ Under \ 24t \\ \hline 16 & Yrs. & Months & Days & Hours & Manches & M$	Aug. 17,1992 South						
Aaryland 28a-f show any 1 at once. ector	MD Anne Arundel	10c. City, Town or Location Annapolis	10d. Inside City Limits 1 Yes 2 X No						
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 106 East Severn Ridge Road	10f. Zip Code 21409	10g. Citizen of What Country? USA						
2 hours after death wi "natural", or items Examiner must be	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	If Yes, specify Cuban, Mexican, Pue X No 1 Yes 2 No specify: pleted) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	white, etc. Specify: White f work done 16b. Kind of Business/Industry						
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than " her transmatic event, the Micheal To Be Complet	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Surname)						
2121 uld;be fill Mental I marked t event,	wayne A. beverry		rly Nelson or Rural Route Number, City or Town, State, Zip Code)						
	Wayne A. Beverly/ father	106 East Severn Rid	ge Road Annapolis, MD 21409						
Baltimore, permit. Pages I at Department of Hee Important: If ite	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify: 21. Signature of Funeral Service bicensee		an. 30, 200. Location - City or Town, State Elkridge, MD						
Derm perm Depa Impe	pl Can		P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146						
Physician /Medical xaminer	23a Fart I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a conse	10:01	c or respiratory arrest, shock, or heart Approximate interval Between Onset and Death						
vecuted and - transit	events resulting in death) Last Due to (or as a conse								
6 2 - 0	UNPENDED AMENDED								
	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. D								
b, P.O. Bo ires that the de signed by the 1 be detached f		but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown						
cords law requestable been 2 should			24a. Was an autopsy performed? 1 ✓ Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
Vital Rec hysician: The this certificate I director, page	25. Was case referred to medical examiner?	26.Place of Death (Che nt 2 ✓ ER/Outpatient 3 DOA Other Nu	ck only one) sing Home 5 Residence 6 Other:						
ion of \\ itending Phy feath tor: After th the funeral or	27 Manner of Dooth	ry 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject hanged self						
Division or Attending within 24 hours after death To the Finneral Director: After completely filled in by the funcedical Certification:	3 V Suicide 6 Could not be determined (Specify) resi	ury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 106 Severn Ridge Rd E, Annapolis , MD						
To the Hos within 24 h To the Fun completely	29a, Certifier	/ knowledge, death occurred at the time, date and place, a nination and/or investigation, in my opinion, death occurre							
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 26, 2009						
ICHT	30. Name and address of person who completed cause of de	eath (Item 23a) ledical Examiner 111 Penn Street, Baltim	ore, MD 21201						
, State Registra		's Signature, Sarks							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Registrar

Bark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM ROBERT 5:45 A_M 5<u>,</u> February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, June 3, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral Days Year) 1920 Months Hours Min. 1⊠M 2□ F 131-22-0167 88 New Jersey Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland Director St. Mary's 1 ☐ Yes 21 No California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23133 Marble Way 20619 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 marked other than "natural", or 1 ☐ Yes 21 No ٥ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S. Government 12 4 t. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 Is marked other t ajury or other traumatic event, Ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Herman Brandes Charlotte Kamena 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Edith Brandes / Wife 23133 Marble Way California, MD 20619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 7. Injury or permit. Page Department o Important: If any Injury or 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 23a. Part 1 (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ninutes resulting in death) /Medical Due to (or as a consequence of): Examiner HOURS MYOCARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan; The law requires that the death certificate be executed Coronary and I-trans physician are the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performed? Yes 2 No of Vital 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division Japitar ... 4 hours after dea... ral Director: After ... 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after dear To the Funeral Directo completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

FEB 10 31. Date filed (Month.

DAmas

I Ames

32. Registrar's Signature

PO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

box 5

2982

Registrar DHMH 17 Rev 1/2001

State

William D. Boyd II, M.D.

10

31. Date filed (Month, Day, Year)

25365 Point Lookout Road

32. Registrar's Signature

Leonardtown, MD 20650

Box 68760. P.O. | Division of Vital Records,

Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral C



29a. Certifier tpreftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056096 2-10-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A JBINDGR 5 7 GILL STMARYS

2. Registrar's Signature

MOSPITAL LEONARD TOWN MIS 20058

State Registrar 31. Date filed

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4, 2009 **Physician** Michael Alan BOYD, SR. 4:10pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1806 Winston Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1 ☑ M 2 □ F 284-46-0182 60 1948 Ohio Nov. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Maryland Washington 1 ☐ Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 1806 Winston Drive 21742 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deau Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural any injury or other traumatic enterment." 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status ¥Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: black Specify: ð 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manager finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Oscar ပ္ Boyd Mattie Hampton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassaundra Boyd - daughter 11724 Elkwood Drive, Cincinnati, Ohio 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) 2009 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Natural Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2 □No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes 2 □ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JH-7+ Norther, Av Week MP 31. Date filed (Mor Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2009	9	183		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOITON (107	plau	OF MO 20607
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	Physici /Medi		Decedent's Name (First, Middle, Last) Violet Bingaman			2. Date of Deat Month Fabruai	Day Vo	the state of the s
	Examir	ner	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or L Hagerst If Under 1 Year	own	1	Washing	ton
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 IF 7. Age (In yrs. last birthday) Usual Residence of Decedent 7. Age (In yrs. last birthday) Vrs. 84	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/1/192	Year) 9.	Birthplace (State or Foreign Country) PA
	the Maryland 28a-f show	Director	PA Franklin Greencas 10a. State 10b. County 10c. City, Town or Lo			1.1	Do Citizon of What	10d. Inside City Limits 1 ☐ Yes 2X No
	3a or		3434 Scar Hill Rd.	17225		'	09. Citizen of What USA	Country?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanduer mast be notified at once.	by Funeral	1 ∐ Never Married 2 X Married 1 ∐ Yes 2 X No	Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 ☑ No	spanic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
Baltimore, Maryland 21215-0036	within 72 hoiene. than "natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupat kind of work done du DO NOT use retired) Homemake	ıring most of work	sing	16b. Kind of Busine	
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	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 → Certifying Physician: To the best of my knowledge, death and manner stated.	n occurred at the time vestigation, in my opir	e, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
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			30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)		HAGER	•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DLEMAN Month **Physician** 2/3 UM NOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Camp Springs 5301 Fadden Court If Under 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F Director 8/19/1927 579-28-3139 81 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the "nedical Examinar must be notified at Director 1 XYes 2 □ No Maryland Prince George's Camp Springs 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 5301 Fadden Court 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Service Driver Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Coleman Willie Mae Burnside ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mildred Coleman / Wife 5301 Fadden Ct. Camp Springs, Maryland 20748 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2/4/2009 Fort Lincoln Brentwood, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Licen 5538 Marlboro Pike Forestville, Maryland 20747 Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. Approximate nterval Betweenset and Immediate Cause (Final en **Physician** w disease or condition resulting in death) /Medical Due to (or as a consequence of): nerturion Examiner an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.0. the 1 □Yes 2 □No detached 9 Unknown 2 s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 154 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? law 24a. Was an has page 2 autopsy certificate I Division of Vital 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No ospital or Attending Physician: hours after death. director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending within 24 hours after use...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier Date signed (Month, Day, Year) 40 61

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Death
Reg. No. 2009 1 - State Registrar 05019 2. Date of Death 1. Decedent's Name (First, Middle, Last Day 2009 Month **Physician** 12:55 PM 30. unning QN-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner inton land If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Se 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 5 Months Hours Min. 250.96.663 Days Carolina Director -01-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or items 23e or 28e4 show any Injury or other traumatic event, it is finding any injury or other traumatic event, it is finding a PG 1 Yes 2 No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20748 ongvieu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced slack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use letired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) alker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21054 wife) Gambris unningham 1erc xreen oregette 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 1 ☐ Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Sville rem 22. Name and Address of Facility Beech Road Freemantuneral Services Temple Hills LI N 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** 31/NKYA) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MROSINC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificete be executed Chuntr the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 □Yes 2 V No 2 🗆 No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death eccurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29a. Certifier Medical (Check only one) oginion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50) C)14 804 Ju-notos Just

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 0 5 2009

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 05020 State of Maryland / Department of Health and Mental Hygiene

Anton	io Lamont		- For State	State	e of Maryla		epartmer <i>Certificat</i>		ealth and M eath	1ental Hy		g. No.		, , , , , ,
	Physicia	an/	1. Decedent's Nam	e (First, Middle,La	est)					2	2. Date of Deatl Month	n Day	Year	3. Time of Death 0312 hrs
Medi	cal Exami		4a. Facility Name (i			nber)		4b. C	ity, Town, or Loca	ation of Death	January 30), 2009	ounty of Death	
())			rges Hospital		,			neverly			Prin	ce George	e's
	Funeral Director		5. Social Security N 220-17-3	1400	Sex 2 F		yrs. last birthd	_		Hours Min	8. Date of Birt 08/01/1	,	Foreig	thplace (State or in ur Maryland
	any	Ī	Usual Residence of 10a. State	f Decedent 10b. County		10c.	. City, Town or	Location						10d. Inside City Limits
	*	ايا	Md.	Prince	George's	5	Upper	Marl	ooro					1 X Yes 2 No
	farylar 28a-f s I at on	Director	10e. Street and Nu	mber				10	. Zip Code		10	g. Citizen	of What Cou	ntry?
	h the N 3a or			insbury F					2077				S.A.	
	or items 23a or 28a-f show in ust be notified at once.	Funeral	11. Marital Status 1 Never Marri		12. Was Dece and Armed Fo 1 Yes and If Yes, Give Year	rces?		If Yes, s	cedent of Hispanion pecify Cuban, Mes	exican, Puerto R			White, etc.	ican Indian, Black, African— American
	ırs afte tural", tnine	d b	3 Widowed 15. Decedent's E		or Dates:			ecedent's U	sual Occupation ((Give kind of wo			of Business/	
	5 72 hou in "nat	Completed	Elementary/Sec	ondary (0-12)	College (1	-4 or 5+)	1	•	of working life. DO	NOT use retire	ed)			
	within jiene.	dwc	11th 17. Father's Name	/F:	-4\		Uı	nemplo		Nother's Name (Eight Middle A	Asidon Sur	Non	е
i	21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be		y Leo F]	•					Cecilia			name;	
	21 lould b d Men is marl	To E	19a. Informant's Na						dress (Street and					•
	MD 2 sho alth and an 27 is		Grace Fl		Frandmoth				(Name of cemeter		er Mar]		Md. 2 ation - City or	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 4 Donation 5	Cremation :	ify:	om State		y or other p ection	n Cem.	02/	07/09	Cli	nton,M	aryland
i	Ball permit Depart Impor		21. Signature of Fu		ensee	als		4925	S.Washind Burroud	gton & hs Ave.	Sons Co	Jashi	c. naton.	D.C.20019
	Physician /Medical	ia lis	23a. Part I. Enter the failure. List or	ne disease, or cor nly one cause on	each line.	aused the	death. Do not	enter the m	ode of dying, such	h as cardiac or	respiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
	Examiner		Immediate Cause or condition resulti	(a. Asphyxia Due to (or as a	conseque	ence of):							
		<u>.</u>	Sequentially list co	onditions,	b. Hanging Due to (or as a	conseque	ence of):							
		Examiner	if any, leading to in cause. Enter Und (Disease or injury events resulting in	erlying Cause that initiated	Due to (or as a			(7 <u>55</u>)						
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	760, cate be ex physician he burial	Med	IF FEMALE:				f pregnancy						ate of deliver	
	30x 6876(leath certificate e attending physicures as the b	sician/M	23b. Was decedent past 12 month		1 Live b	irth ant at time	e of death 5	Fetal o	eath 3 E	Ectopic pregnar	псу	Mo	onth	Day Year
	Box e death c the atten ed for us	Physi		No 9 Unkno	9 OHKIR									
	i, P.O. ires that th signed by I be detach	ξ	Part II. Other sign	nificant condition	s contributing to	death bu	t not resulting	in the unde	rlying cause giver	n in Part I.			-	the cause of death? bably 4 Unknown
	ords, w require s been si should b	Completed									24a. Was			utopsy findings available completion of cause of
	ecol ne law te has l ige 2 sh	ldmc									perfo	rmed?	death?	es 2 No
	ital Recional The list certificate lector, page	Be Co	25. Was case refe	rred to medical						Death (Check o	L	<u> </u>		
	Vita Physici r this c al direc	To E	examiner?	2 No		<u> </u>	2 FR/Out		DOA Oth	4 INGISHING	Home 5	Residence		er:
	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		27. Manner of Dea 1 Natural 2 Accident	5 Pending	Jan 30,	Day,Year)	FOUN 0231	hrs	1 Yes	2 V No	28d. Describe Subject han	ged self	f 	
	Division pital or Attend ours after death. eral Director;	Certification:	3 Suicide 4 Homicide	6 Could n	ot be		- At home, far Family	m, street, fa	actory, office build		28f. Location (or Town, \$ 2119 Samsbu	State)		ural Route Number, City oro, MD
	Div To the Hospital o within 24 hours af To the Funeral D completely filled i	Medical (29a. Certifier 1 (Check only one) 2	Certifying Phys Medical Examin	sician: To the besiner:On the basis and manner s	of examina	nowledge, deat ation and/or in	h occurred vestigation,	at the time, date a in my opinion, de	and place, and eath occurred at	due to the caus t the time, date	se(s) and m and place,	nanner as sta , and due to t	ted. he cause(s)
	⊢ ≯ ⊢ 8	Me	29b. Signature and	d title of certifier	nell M	D	_		29c. License nu O.C.M.E			ı	te signed (Mo try 30, 200	onth, Day, Year)
cr			30. Name and add		no completed cau Assistant Me			111 Pen	n Street, Balti	imore, MD 2	21201			
	S	tate	31. Date filed (Mo	nth, Day, Year)	32. R	egistrar's S	Signature.	7						·
	Regis		EEB 0.3	2009 /	Garage .	A. A								
DΗ	IMH 17 Rev 1/	2001					URI	GINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	State Registrar	Ce	ertificate of Death		g. No. 2009 3. Omebr Death	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Elnathan Osho	Coker		2. Date of Death Month January	29, 2009 2:05 A. M	
Examiner	4a. Facility Name (If not institution, give street and Laurel Regional Hospi		4b. City, Town, or Location of Dea	th	4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 6. Sex 1 M № 2 □ F	7. Age (In yrs. last birthda 61 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min			
wor the	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			10d. Inside City Limits	
or 28a-f sl	Maryland Montgomery	Burt	tonsville	10	1 X)Yes 2□No	
a or 2 the n	10e. Street and Number 3415 Greencastle Road		10f. Zip Code 20866	10	g. Citizen of What Country? United States	
and wenter riggers. and wenter right in the motival Exercitive must be notified at summatic event, the Motival Exercitive must be notified at To Be Completed by Funeral Director	11. Marital Status 12. Was D Armed	s 2 VT No	I 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
al Exam al Exam ed by	If Yes,	Give r Dates:	1 ☐ Yes 2 ▼ No Specify:	1	Specify: Black 6b. Kind of Business/Industry	
Yelene "natura t, the Modell Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	e(1-4or 5+) (Giv life	ve kind of work done during most of wo b. DO NOT use retired)	orking		
S C	17. Father's Name (First, Middle, Last)	rs Auto	omoblie Salesman	me (First, Middle, M	lexandria Toyota aiden Surname)	
arked oth attc even	Elnathan Coker, Sr	•	Glady			
s mar	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	illing Address (Street and Number or F	Rural Route Number,	City or Town, State, Zip Code)	
n 27 l	Annie F. Beckley (Sis		10 Cudby Court; La			
Department of neutral and month of the mortant: If item 27 is marked any injury or other traumatic events. Once. To E	20a. Method of Disposition 1	om State	position (Name of rematory or other place) Washington Cemeter	.14,2009	Oc. Location - City or Town, State delphi, Maryland	
Importa any inju once.	21. Smature of Funeral Services Cosmoce	0//	22. Name and Address of Facility $old R$.	N. Horto	n Company Morticians.;Washington,D.C.200	
	23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not e				
s the burial-transit a the burial-transit and and and and and and and an	Sequentially list conditions, if any, leading to immediate occurs. Each Undership Cause (Disease or injury that initiated events resulting in death) Last Due					
by the attending ached for use a ached for use and was a way and was a character and w	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to Hypertension	death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? s 2 ☐ No 3 ☐ Probably 4 🛣 Unknov	
hage pe 2				24a. Was an autopsy perform 1 □ Yes 2	prior to completion of cause o death?	
4 C) 4 S	25. Was case referred to medical			eath (Check only one		
ctor, p	examiner?		O45	28c. Injury at 28d. Describe how injury occurred		
After this certificate funeral director, pag	27. Manner of Death 1 Natural 5 Pending	☐ Inpatient 2 🔀 ER/Outpat ate of Injury flonth, Day, Year) 28b. Time Injury	e of 28c. Injury at Work?			
Director: After this certifica d in by the funeral director, p ertification: To Be C	1 Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 5 Pending (No 1) 2 Accident investigation 3 Suicide 6 Could not be determined.	ate of Injury 28b. Time	of y M 1 Yes 2 No	28d. Describe how	w injury occurred eet and Number or Rural Route Number,	
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DHMH 17 Rev 1/2001

			, ror	State of Maryland				iental Hygi	ene	
		1	_ State Registrar		Certific	cate of D	Death		3. No. 2 0 0 9	05022
	Physicia		1. Decedent's Name (First, Middle, Last) WALTER ALEX	ANDER COPE	LAND			2. Date of Death Month JAN . 2	28°, 20°9	3. Time of Death 6:15 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give st				Location of Death		4c. County of Deat	
est."			Bethesda Healt				esda	0.5.4.4.50.4	MONTGO	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs. Mon	nder 1 Year oths Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 16.		thplace (State or Foreign ountry) cryland
	Director	ŀ	220-38-3248 Usual Residence of Decedent	65				Mar 10,	19431 146	
	yland how		10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
:	sa-f s	당	MD Montgo	nery	Rockvi					1 √Yes 2 No
	2 of 1	Dire	10e. Street and Number	7 G	101	f. Zip Code	Ε.Ο.	10	g. Citizen of What Co	
	s 23a	eral	15313 Gable Ric	2. Was Decedent Ever in U.S.	13 Was D	208		ecify Yes or No-	U.S.A.	
•	be filed within 72 hours after death with the Maryland Hylgiene. do cither than "natural", or items 23a or 28a-f show event, the Medical Evamine riust by nutified at	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	Armed Forces? 1 Ves 2 No If Yes, Give			spanic Orlgin? (Sp n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
2-003p	al", o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 62-65	5 1 1	es 2⊠No	Specify:			Black
ر ا	'natu	Completed	15. Decedent's Educa (Specify only highest grade		16a. Decedent's	of work done d	uring most of work	ta a. 911	6b. Kind of Business/ Federal	Industry Bureau of
2	within	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		or use retired) tion P	rogram		Prisons	Bureau or
N E	Hygid Hygid Sther		12th 17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M.	aiden Surname)	
and	ould be filed within / d Mental Hygiene. narked other than "r natic event, the Med	To Be	Howard Copela:	nd, Sr			Rache	l Ross		
Mary	es 1 and 2 should be of Health and Mental fitem 27 is marked or other traumatic ever	П	19a. Informant's Name/Relationship (Typ		19b. Mailing Add	dress (Street a	and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
e, Ge	and		Doris Copeland						kville, M Oc. Location - City or	
ore	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ce of Disposition metery, crematory		i .		•	
altimor	iff. Pa urtmer intant: njury		4 □ Donation 5 □ Other (Specity) 21. Sign * re of Funeral Serv Livens		ryland				Crownsvi	IDME, P.A.
g	permit. Pages Department of Important: If it any injury or conce.		en signification rule all services the latest	Anont o						MD 20850
T			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death,						Approximate Interval Between
-	hysician		Immediate Cause (Final disease or condition	Adenocaro	rinoma	of Un	known w	ith		Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):					
~	Examiner	L.	Sequentially list conditions, b.	Metastas		liver				
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ν. -	be executed ician and burial-transit	Exai	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
8760	icate be executed physician and the burial-transit	dical	U d.							
	ertifica ing ph e as th	Med	IF FEMALE:				-			
Box	eath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand	death 3 🗌 Ecto	opic pregnancy	/		23d. Date of de Month	Day Year
0	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ain 5 🗆 Oin	er (specify)				
J	w requires that the dispersion signed by the should be detached		Part II. Other significant conditions con	tributing to death but not result	ting in the underly	ying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	quires en sige uld be	d by	Anemia,	Poor intake				1 ☐ Ye	s 2 No 3 P	robably 41 Unknown
000	law rei as bee 2 shoi	plete		to Thrive				24a. Was an	24b. Were a	utopsy findings available completion of cause of
ř	The The page	Completed						perform	ed? death?	s 2□No
Vital	hysician: The Is his certificate ha I director, page 2	Be C	25. Was case referred to medical examiner?			Lou		th (Check onl one)	
	Physi this c		I∐ tes 2xx 140	ospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury 2	R/Outpatient 3 28b. Time of	DOA Othe	4 A Nursing H	ome 5 Reside	nce 6 Other (Spenier)	ecify)
חס	ding F h. After funera	tion	27. Manner of Death 1 XNatural 5 Pending investigation	(Month, Day, Year)	Injury N	Work	yan (? Yes 2 □ No	200. Describe no	w injury occurred	
Division of	al or Attending Physician: T s after death. I Director: After this certificat sd in by the funeral director, ps	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, fa	actory, office		28f. Location (Str. City or Town	reet and Number or F	Bural Route Number,
á	al or s after al Dire	Certification: To	4 Hornicide	building, etc. (Specify)				·		
	the Hospital or hin 24 hours afte the Funeral Dire mpletely filled in b	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death occ on and/or investi	curred at the tir gation, in my o	me, date and place pinion, death occu	e, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	8		> Chavid	ry /		D4	3121		1/31/09	
	U		30. Name and address of person who co	moleted cause of death (Item						
			Nural Chowdhu	2 .		ino Dr	ive, Bu	rtonsvi	lle, MD	20866
	Sta	ate	31. Date filed (Month, Day, Year)	37. Registrar's Signatu	6. 4					

DHMH 17 Rev 1/2001

09-00793 Helen Clapsaddle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State 3 Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) 0023 hrs Physician/ January 27, 2009 Medical Examiner HELEN ELAINE CLAPSADDLE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 600 Admiral Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Country MARYLAND Hours MAY 27, 1964 **Funeral** Months Days M 2 X F Director 220-72-9095 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No ANNAPOLIS ANNE ARUNDEL MARYLAND or items 23a or 28a-f show must be notified at once. 109. Citizen of What Country? the Maryland 10f, Zip Code 10e. Street and Numbe UNITED STATES 21401 600 ADMIRAL DRIVE, #515 喜 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. death with If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Funeral Armed Forces? Never Married 2 Married 2 X No Specify: WHITE Yes Yes 2 X No specify: Yes, Give Year 4 X Divorced Widowed 3 16b. Kind of Business/Industry within 72 hours after 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) AUTOMOTIVE other than " the Medical I ACCOUNTANT ermit, Pages 1 and 2 should be filed within spartment of Health and Mental Hygiene. portant: If item 27 is marked other than iry or other traumatic acceptance. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HELEN ARGATHA JACKSON JAMES JEHU MULLENS Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 627 RIDGELY AVENUE, #5, ANNAPOLIS, MD 21401 10 JUDITH C. DEAN/SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition CHESAPEAKE CREMATION FEBRUARY 1, 2009 STEVENSVILLE, MARYLAND Removal from State Burial 2 X Cremation 3 CENTER HELFENBEIN AND ARE PA., 814 I ND 21401 22. Name and Address of Facility FELLOWS HE CREMATION AND FUNERAL CARE ROAD, ANNAPOLIS, MARYLAND Donation 5 Other Specify Baltil
permit,
Departm
Importa 21. Signature of Funeral Service Licenses M00672 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Physician failure. List only one cause on each line. a. Intraoral gunshot wound /Medical Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760, IF FEMALE: Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 Unknown Records, P.O. Yes 2 ✔ No 3 þ 24b. Were autopsy findings available 24a, Was an Completed prior to completion of cause of autopsy death? performed 1 🗸 Yes ✓ Yes 2 certificate 26. Place of Death (Check only one) To the Hospital or Attending Physiciau: within 24 hours after death.

To the Funeral Director: After this certific cympletely filled in by the funeral director. 25. Was case referred to medical Residence 6 V Other: Scene Other, Division of Vital Be Nursing Home 5 examiner? DOA Hospital: ER/Outpatient 3 Inpatient 2 No 28d. Describe how injury occurred 1 Yes 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year Jan 27, 2009 27. Manner of Death Subject shot self 1 Yes 2 ✔ No Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) 600 Admiral Drive, Annapolis, MD Could not be 3 V Suicide (Specify) Multi-Family Apt. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

State Registrar 31. Date filed (Month, Day, Year)

32. Pegistrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05024 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle-Last) 2. Date of Death ORNAISON **Physician** Month ()23 OM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/09/1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 M Oklahoma 85 Director 509**-**22-8945 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2PNo Directo Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2891 Spring Lakes Drive 21035 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, tre Medical Examiner must any injury or other traumatic event, tre Medical Examiner must ponce. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖔 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Perry George Soloman Sparks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2891 Spring Lakes Drive, Davidsonville, Maryland 21035 Carlos A. Giglione/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/30/2009 Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) Kalas Crematory 21. Signature of Frank Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mille 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or es a chasequence of): Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician end I be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Ai completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print SLD

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

2. Date of Death Month

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3. Time of Death

Physicia	Ī
/Medic	
Examin	

Decedent's Name (First, Middle, Last)

	Physici /Medic										
	Examir		4a. Facility Name (If not institution, give street and number) 2412 CHESTNUT GROVE ROAD		4b. City, Town, or Loca	ition of Death PSBURG	4c. County of Death WASHINGTON				
	Funeral Director			s. last birthday) Yrs.	If Under 1 Year If U	inder 24 Hrs. 8. Date of Bir (Month, Date of CT. 10	th g. Birthplace (State or Foreign Country)				
	ס	J.	Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Lo			10d. Inside City Limits 1 □ Yes 2 ☒ No				
	ith the Mi or 28a-f	Director	MARYLAND WASHINGTON 10e. Street and Number		10f. Zip Code	PSBURG	10g. Citizen of What Country?				
36	be filed within 72 hours after death with the Maryland ntal Hyglene. Id other than "natural", or Items 23a or 28a-f show event, its "in after Exx. is or must be mylified at	by Funeral	2412 CHESTNUT GROVE ROAD 11. Marital Status	54-		ic Origin? (Specify Yes or No exican, Puerto Rican, etc.) ecify:	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE				
1215-00	within 72 hour iene. t han "natura l"	Completed t	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 19 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced	dent's Usual Occupation kind of work done during DO NOT use retired)		16b. Kind of Business/Industry				
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, Mary	is 1 and 2 should lot Health and Men Item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Type. Print) FREDA WILLIAMS/SISTER	2410	CHESTNUT GR	OVE ROAD, SHA					
Itimore	t. Page: rtment o rtant: If		TED But at 2 Cremation 3 Ed Hernoval from State	'. MORRITA	sition (Name of matory or other place) AH CEMETERY Name and Address of the control of the cont	2/14/2009	20c. Location - City or Town, State ALBRIGHT, WEST VIRGINI FER FUNERAL HOME				
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o.		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of preg. 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year				
Vital Records, P.	The law requires that the ate has been signed by the bage 2 should be detache	Completed by Pi	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in I		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an 24b. Were autopsy findings available				
ital Re		w	25. Was case referred to medical		26.	auto perfo 1 □ Yes	ormed? death? 2 No 1 Yes 2 No				
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D		Σ	29b. Signature and title of certifier Step L- Ket L; mo,		29c. License num		29d. Date signed (Month, Day, Year) Feb 5, 2009				
<u>ح</u>	H-5+1	ate	30. Name and address of person who completed cause of death (Ite 1997) 1. Date filed (Month, Day, Year) 32. Registrar's Sign	-K.tu	Print) 57. H.	of it ma	21740				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 30, 2009 1:40 Josephine R. Corigliano January /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10/11/1903 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral 1 M 2 F Italy 105 072-01-7098 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ➡No Director Mitchellville Prince George's 10g. Citizen of What Country? 10e. Street and Number 20721 USA 3800 Lottsford Vista Rd. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ (☐No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Garment Seamstress i. Pages 1 and 2 should be filed w tment of Health and Mental Hygie trant: if Item 27 is marked other ti jury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paola Aversa Vincenzo Repace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela C. Murphy / daughter 6714 McDonough Terrace Bowie, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial /2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Resurrection Cemetery 2/4/2009 Clinton, MD 4 ☐ Donaylon 5 ☐ Other (Specify) Beall Funeral Home 21. Signature of Fun val Service Licensee 22. Name and Address of Facility Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List doly one cause on each line. Approximate Interval Between Onset and Death **Physician** Chronic Obstructive Pulmonary Disease vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, nding physician Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Sick Sinus Syndrome Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure cate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Dementia of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one director Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို this Liter death.

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*In by the function of the function of the function. funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certified 1/30/2009 KU6848 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millie Jarrell, CRNP 14300 Gallant Fox Lane Bowie, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 02 2009

DHMH 17 Rev 1/2001

Registrar

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Ö	law r as be	ple										24a. Wa		24b. Were	autopsy	findings a	vailable
Œ	The law cate has page 2 s	Completed										peri 1□ Yes	ormed?	death	1?		.030 01
Vital	ician: Th certificate rector, pag	Bec	25. Was case referre	d to medical						26. Place	of Death	(Check only					-
f V	S	To	examiner? 1 ☐ Yes 2 ☑ N	lo	Hospital: 1 ☐ In	oatient 2	ER/Outpatien	3 DOA	Other	" ALTAN	rsing Hon	₩ 5X Res	idence	6 ☐Other (S	pecify)		-
o of	g Ph er th ieral		27. Manner of Death		28a. Date of		28b. Time of	28c.	Injury Work			8d. Describe					
Division	Attending I r death. ector: After by the tuner	atio	1 ZNatural 2 ☐ Accident	5 Pending investigat		Day Year)	Injury	М		es 2 🗆 t	No						
/is	l or Attendi after death. Director: A	ifica	3 🗌 Suicide	6 Could not determine	ad 286. Place c	f Injury - At ho	me, farm, stre	et, factory, o	ffice		2	8f. Location	(Street ar	d Number or	Rural Ro	ute Numb	oer,
ā	spitel or A ours after verel Direc filled in by	Certification;	4 🗌 Homicide		building	g, etc. (Specify	1)					City or To	wn, State)			
	e Hospitel 24 hours e Funerel etely filled		29a. Certifier 1	Certifying	Physician: To the b	est of my kno	wledge, death	occurred at 1	he time	e, date and	d place, a	ind due to the	cause(s)	and manner	as state	d.	
	24 ł 24 ł 9 Fu etely	Medical	(Check only 2 one)	Medical Ex	aminer: On the bas and manne	is of examinat	tion and/or inv	estigation, in	my opi	nion, deat	th occurre	ed at the time	, date and	d place, and	due to the	cause(s)	
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in b	Me	29b. Signature and ti	tle of certifier		1.	20.1	29c. L	icense	number			29d. Da	te signed (Mo	onth, Day	, Year)	
	- 5 - 0		- gen	brech	- prome	M	(OU)	Z	100	25	82	13	11	1291	19		
	,		20 Name and address	an of possess and	no completed eases	of death (Its	1000) (Tours	Daim N						te signed (Mo			
1	2 Cel		30. Name and address	Corela	way Itr	Dri	23a) (Type,	en 60	11	MI	9 2	0.7	70	Farhad	Jama	li MD	
(VOI.		31. Date filed (Month	Day Year)	32 Ra	uistrar's Signa	ture		-(-				
	Sta Registr		Date ined (moriti	FERMO	2000	Januar G Grigi Id	4	1	,								
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	Exan
	Direction in the pure of the p
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at

7	/Medi	cal	BEHY L. Chapma	in				FEBRUA	RY 3, 2	:009	12:33 A [™]
1	Examir		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or	Location of Death		4c. Count	y of Death	n
			75 COKESBURY ROAL)		PORT	DEPOSIT			CECI	L
S .	Funeral Director		217-30-2470	x 7. Age (<i>In yrs. l</i> asi	t birthday) If Und Months	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da SEPT 05	h y, Year) 1 933	9. Birth Cou MAF	nplace (State or Foreig untry) RYLAND
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Location						10d. Inside City Limits
	anyla shov	2		_							1 ☐ Yes 2 ☑ No
	8a-f	Se le		CIL		RT DEI	POSIT		10 0''' 1		**
	or 2	Ö	10e. Street and Number	210	10f. 2	Zip Code	21004		10g. Citizen of		
	s 23a	ra	75 COKESBURY RO		40 W - D -		21904	anife Van an Na	14 Pa	US.	A nican Indian,
	er de items	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	If Yes, sp	pecify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Bla	ack, White	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No No	Specify:		Speci	ify: BL	ACK
응	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	- B	15. Decedent's Edu		16a. Decedent's Us	sual Occupa	ation		16b. Kind of E	3usiness/l	ndustry
15	in 72 n "na Aedic	Bet	(Specify only highest grade Elementary/Secondary (0-12)	(e completed) College (1-4or 5+)	(Give kind of v life. DO NOT	work done o use retired	luring most of work)	ring			•
21215-0036	yiene. r than the M	Completed	12	College (1-401 5+)	FOOL	SERV	/ICE		VA H	OSPI'	TAL
Þ	al Hygid other vent, th	BeC	17. Father's Name (First, Middle, Last)	•			18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
<u>a</u>	Mental arked o	70 0	MORTAN BROWN				BERTHA J	ONES			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (T)	vpe. Print)	19b. Mailing Addre						
	1 and 2 Health tem 27 I		GEORGE B. CHAPMAN	, SR. / HUSBAND	75 COI	KESBUI	RY ROAD,	PORT DE	POSIT,	MARY.	LAND 21904
Baltimore,	es 1 and the filter		20a. Method of Disposition	com	e of Disposition (Netery, crematory o	lame of or other plac	e)	Date	20c. Location	- City or	Town, State
Ĕ	Page nent ant: If		1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		ZOAR A.M.	E. CE	M. 02/	07/09	CONO	WINGC	, MARYLAND
a	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funeral Service Licens	see			ss of Facility T FUNERA	T LIOME	ת מ		
Ω_	88 = 88		dia Scot	t-Coleman	552	LEWIS	STREET,	L HOME, HAVRE	P.A. DE GRAC	E. M	D 21078
E			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not enter the m	ode of dyin	g, such as cardiac	or respiratory a	rrest,	200	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Myocardi	al Tr	fax	chion				Onset and Death
7	the death certificate be executed y the attending physician and ched for use as the burial-transit		resulting in death)	Due to (r as a consequer							
		١.	Sequentially list conditions	Diabetes	Mel	lita	vs -				2073
		Examiner	Sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer		.1/					70111
		am	that initiated events resulting in death) Last	c. Synchel	al K	stur	na.				30913
30,	oe ex			I Land O CONSequer	اره ۱۱۵ ما. مرکزی در	1000					
68760,	cate b	gi		d. Hyper Cha	sus fin	COPP	<i>A G G</i>				
9 x	ding page as	ysician/Medical	IF FEMALE:	23c. If yes, outcome pf pregnanc	**/						
Box	w requires that the death cer been signed by the attendin should be detached for use	ian	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal	eath 3□Ectopic				- 1	ate of deli fonth	very Day Year
O.	the de	ysic	1 ☐ Yes 2 ☐ Ño 9 ☐ Unknown	9☐Unknown	ui 3 doniei	(specify)					
4		直	Part II. Other significant conditions co	ontributing to death but not resulting	ng in the underlying	g cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of death?
Records,	The law requires that ate has been signed b	d by						1 🗆	Yes 2 No	3 🗌 Pr	obably 4 Unknow
Ö	v req been shoul	Completed						24a. Was	an 24h	Woro ou	topsy findings available
Re	e la has je 2	E E						auto		prior to death?	completion of cause of
7			OF Was once referred to medical					1□ Yes	2No	1 🗆 Yes	2 □ No
Vital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	2/Outpotiont 20	DOA Oth	26. Place of Dea				
o		2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 2	R/Outpatient 3 8b. Time of	28c. Injur	4 □ Nursing H	28d. Describe	dence 6 🗆 O		oity)
on	ding Ph h. After th funeral	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Worl	k? Yes 2 □ No				
Division	Attending r death. ector: Afte by the fune	Certification:	3 Suicide 6 Could not be	Zoe. Flace of injury - At nome	e, farm, street, fact	tory, office		28f. Location (Street and Num	ber or Ru	ıral Route Number,
É	after after Dire	erti	4 ☐ Homicide determined	building, etc. (Specify)				City or To	wn, State)		
	• Hospital or Attence 24 hours after death • Funeral Director: etely filled in by the i	alC	29a. Certifier 1 Certifying Phy	ysician: To the best of my knowle	edge, death occurr	ed at the tir	ne, date and place	, and due to the	cause(s) and r	nanner as	stated.
	e Ho 1 24 f e Fu letely	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	n and/or investigat	ion, in my o	pinion, death occu	rred at the time	date and place	and due	to the cause(s)
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Me	29b. Signature and title of certifier	4	1	29c. Licens	e number		29d. Date sign		
-			* KNYN	B. Parekh	mp. j	000	18424	<i>i</i>	Feb-	4-2	2009
	FT		30. Name and address of person who of	completed cause of death (Item 2							
	/		B.D. Parekh M). 1908 Hart	3a) (Type, Print) Ford Rea	of FZ	allston 1	40 21	047		
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur							

DHMH 17 Rev 1/2001

State

Registrar

FEB 0 6 2009

B. parks

9-01	052	

Matthew Franklin		per State For State	of Maryland / Depar Cert	tment of ificate of	Health and Death	Mental Hy	Reg.	No. 2	009 05029
Physician Medical Examine	1.	gistrar Decedent's Name (First, Middle,Las MATTHEW F	RANKLIN (COOPER			2. Date of Death Month Death February 4, 2	ay Year 2009	3. Time of Death 1545 hrs
		a. Facility Name (if not institution, giv 26256 Mechanicsville Roa		4	b. City, Town, or Lo Mechanicsvill	е		4c. County of De St. Mary's	
Funeral Director		Social Security Number 6. S	7. Age (In yrs. last XM 2 F 20	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	-	IFo	Birthplace (State or reign Country) MD
w any	1	sual Residence of Decedent 0a. State 10b. County MD CHARLE		Town or Locati					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show		0e. Street and Number			10f. Zip Code 20625		10g	. Citizen of What C	
	neral Di	1 6974 BENNETT 1. Marital Status 1 XXNever Married 2 Marrie	12. Was Decedent Ever in U.s	S. 13. Wa	s Decedent of Hisp es, specify Cuban,	anic Origin? (S	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Al White, et	merican Indian, Black, c.
urs after dea tural", or it	d by Fu		ed If Yes, Give Year 2007 -	16a Doceder	Yes 2X No nt's Usual Occupationst of working life.	on (Give kind of		Specify: N	WHITE ess/Industry
5-0036 filed within 72 hou Hygiene. tother than "na the Medical Ex	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	BUCN	/E-3		ne (First, Middle, Ma	U. S. I	YVAV
1215-0 d be filed w fental Hygis arked offic	Be Cor	17. Father's Name (First, Middle, La DENNIS FRANE 19a. Informant's Name/Relationship	KLIN COOPER		g Address (Street	ANNAI and Number or	Rural Route Numb	KENNA per, City or Town, S	
, MD 2 and 2 shoul lealth and M tem 27 is m traumatic	2	ANNALICE M. V	MOOD/MOTHER 20b.	16974 Place of Dispo crematory or o	4 BENNES	netery, FEI	BRUARY	20c. Location - Ci	ity or Town, State
ti Pages I trisnent of H ortant: If i		1 XXBurial 2 Cremation 4 Donation 5 Other Spec 2 Sgnature of Funeral Service Lice	oity:	VETS	• CEMETER Name and Address	RY 1	7,2009 AYMOND I	FUNL.SE	NHAM, MD RVICE, P.A.
Physician	_	Goren State 23a, Part I. Enter the disease, or co	monomplications that caused the death	0641 5 h. Do not enter	635 WASI the mode of dying,	HINGTO	AVE . ,]	LA PLAT.	A, MD 20646 Approximate Interval Between Onset and
Medical aminer		failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence of	of):		74.÷			Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):						
be executed sician and urial - transi	dical E	UNPENDED	dAMENDED					Date of d	olivon
c 68760, n certificate b ending physic use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	4 Pregnant at time of o	2	Fetal death 3 Other (Specify)	Ectopic pre	gnancy	23d. Date of d Month	Day Year
P.O. Box es that the death c gened by the atten or detached for us	by Physi	1 Yes 2 No 9 Unkn		t resulting in the	e underlying cause	given in Part I.			oute to the cause of death? Probably 4 Unknown
Sords, law requir has been s	Completed b							psy pr prmed? de	/ere autopsy findings available rior to completion of cause of eath? Yes 2 No
tal Rec sian: The l certificate l	1 0	25. Was case referred to medical examiner?	Heavital:			Other	eck only one)	Residence 6	Other: Scene
n of Vita ling Physicia After this cer funeral direct	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Feb 4, 2009	28b. Time 1459 hrs	of Injury 28c. Inj	ury at Work? Yes 2 V No	28d. Describe	how injury occurre fixed object o	ed
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /		2 Accident Inves 3 Suicide 6 Could deter	stigation 28e. Place of Injury - A 28e. Place		treet, factory, office	building, etc.		Ctoto)	er or Rural Route Number, City Mechanicsville, MD
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	4 Homicide	nysician: To the best of my knowl	lodge death or	ccurred at the time, tigation, in my opini	date and place, on, death occurr	and due to the cau	e and place, and a	,
To the within 2 To the Complete complete	Med	29b. Signature and title of certifie	and manner stated.			nse number C.M.E.		29d. Date signo February 5	ed (Month, Day, Year)
		20. Name and address of person	who completed cause of death (I ant Medical Examiner 1	_{Item 23a)} 11 Penn St	treet, Baltimore	e, MD 21201			
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	boules				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 0 9 05030 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Perley January 29, В. Dyer Jr. 2009 10:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgamery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Feb. 17, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours 218-56-8186 57 Director 1951 Maine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No Director Maryland | Prince Georges Lanham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7024 97th Place 20706 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates 1969-1972 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Elementary/Secondary (0-12) College (1-4or 5+) 10 Pick up- Recovery Operator Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Perley B. Dyer, Sr. Regina Barlow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7024 97th Place Lanham, MD 20706 Karen Dyer (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory Feb. 2, 2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Preumonia /Medical Due to (or as a consequence of) **Examiner** Metastatic Lung Cancer with Brain Mets Sequentially list conditions Examine Due to for as a conse juence if any, he dring to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Was a... autopsy performed? Yas 2X No has 1 ☐Yes 2 X No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Box 68760, P.O. Records,

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Division of Vital Hospital or Attending n 24 hours are to he Funeral Director: Andreio filled in by the f death. within 2

State Registrar

npletely

5

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suganthi Alagarsamy 1500 Forest Glen Rd. Silver Spring, MD 20910

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 0 2 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2009

		1 For State		aryland / Depa		lealth and	Mental Hygie	- 2 H H U	05031
Physi	cian	Registrar 1. Decedent's Name (First, Middle, L	•	06	Timeate or i	Jean	2. Date of Death Month	Day Year	3. Time of Death
/Med Exam	lical	Thomas J Doles 3	ve street and number)		4b. City, Town, or		th	24 09 4c. County of De Anne Arui	
Funera Directo		Bayridge Nursing 5. Social Security Number 6. 578-74-2162 Usual Residence of Decedent		ne (In yrs. last birthday) 55 Yrs.	Annapoli If Under 1 Year Months Days	If Under 24 Hrs Hours Min			rthplace (State or Foreign Jountry) Washington D
e Maryland 8a-f show	Director	10a. State 10b. County MD Prince (Georges	10c. City, Town or Lo	le				10d. Inside City Limits ™XYes 2 No
ath with the 23s or 2 ust be on	ral Dire	10e. Street and Number 7423 Jefferson	St.		10f. Zip Code 20784			g. Citizen of What C USA	
17213-UU36 within 72 hours after death with the Maryland ene. then *natural', or liteme 23s or 28s-f show then *matural' and the modified at	by Funeral	11. Marital Status t □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 It Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2000 No	ispanic Origin? (in, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
within 72 ho ene. then "natur	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 10th grade	Education rade completed) College (1-4or	5+)	dent's Usual Occup kind of work done of DO NOT use retired		orking 16	Domestic	•
Maryland 21215-0035 d 2 should be filed within 72 hours aff th and Mental hygiene. th is marked other then "natural", or traumatic event, the Medical Expan	To Be Co	17. Father's Name (First, Middle, Las Thomas J. Doles	Sr.			Clara H			
Baltimore, Maryland ZIZID-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie merked other then "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Modical Examinar must be notified at	once.	19a. Informant's Name/Relationship Linda Doles/Wife 20a. Method of Disposition 1 StBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	⊇ □Removal from State	20b. Place of Dispo cometery, cre Harmony M	B Jefferson (Name of matory or other place [emorial content or con	on St. H		MD 20784 c. Location - City of andover, uneral Ho	4 r Town, State MD
thet the death certificate be executed the estending physicien and detached for use as the burial-transit	ical Examiner	23a. Palm. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Elice Uniceriying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line. a. Advano Due to (or as) b. Due to (or as) c.	d the death. Do not enter the	ter the mode of dyin	g, such as cardia	ic or respiratory arres	t,	Approximate Interval Between Onset and Death
I HECOIGS, P.O. BOX OS The law requires thet the death certifica ste has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy □ Other (specity)			23d. Date of do Month	elivery Day Year
wrequires thet to be been signed by should be detact	b	Part II. Other significant conditions Diabetes	contributing to death t	out not resulting in the u	ınderlying cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
r VITAI HECO ystcian: The law re is certificete has be director, page 2 sho	Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of s 2 \sum No
UNISION OF VITAL RECORDS, P.O. BOX within 24 hours after the death cerwithin 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending completely filled in by the tuneral director, page 2 should be detached for use	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 13 Natural 5 Pending investigate 3 Suicide 6 Could not determine	be 28e. Place of In	ırv 28b. Time o	of 28c. Injur Wor M 1	er: 4 🖾 Nursing	ath (Check only one) Home 5 Resident 28d. Describe how 28f. Location (Stre City or Town,	injury occurred	ecify) Rural Route Number,
To the Hospital of within 24 hours all To the Funeral D	Medical Ce	29a. Certifier XXCertifying F (Check only one) 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	th occurred at the tine	ne, date and plac pinion, death occ	e, and due to the cau	se(s) and manner a	is stated. le to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier 30. Name and address of person	James P	NO	29c. Licens D00368			1. Date signed (Mor	ith, Day, Year)
7	State	Dr. Ajit Kurup 31. Date filed (Month, Day, Year)	, MD 90	0 Van Bure	n St. Anna	apolis M	D 21401		
Regis	strar	FFB 0 2 2009	ancera &	rar's Signature					•

DHMH 17 Rev 1/2001

Certificate of Death

4b. City, Town, or Location of Death

Demetro

05032

1429

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

New Jersey

2. Date of Death 3. Time of Death

4c. County of Death

USA

Montgomery

Race - American Indian.

Own Home

23d. Date of delivery

Feb. 1, 2009

1500 Forest Glen Road Silver Spring, Md20910

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

White

Feb.1, 2009

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Gilda

State Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smitha Bhikkaji M.D.

31. Date filed (Month, Day, Year)

FEBU4

M·D

Physici /Medi Exami

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	State of Maryland / Dep 1 - State Registrar Ce	eartment of Health and Nertificate of Death	Mental Hygien Reg. N	2000 05033						
	Decedent's Name (First, Middle, Last)	3. Time of Death								
an cal	Alice Mae Drake		2. Date of Death Month D February	ay Year						
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death						
	Washington County HospitaL	Hagerstown		Washington						
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 1 M 2 F 1 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)						
	221-16-8318		May 21, 19	27 Maryland						
	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits						
호	Maryland Washington Hagerstown									
irec	10e. Street and Number	10g. C	Citizen of What Country?							
a	1183 Luther Drive	21740		U.S.A.						
Funeral Director		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,						
F	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2☐ No Specify:	Tildari, etc.)	Black, White, etc.						
Completed by	3 ₩Widowed 4 □ Divorced Year or Dates:	**		Specify: white						
lete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry						
	Elementary/Secondary (0-12) College (1-4or 5+)	Nurses Aide		Hospital						
ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide							
To Be	Norman Ecton	Nina Ma	e Ebersole	,						
-		ling Address (Street and Number or Run		or Town, State, Zip Code)						
	Barbara Hammond - Daughter 612	Palm Beach Drive,	Hagerstown	. Maryland 21740						
	20a. Method of Disposition 20b. Place of Disp	position (Name of Ematory or other place)	Date 20c.	Location - City or Town, State						
	To Burlai 2 22 Cremation 3 D Removal from State		/2009 Fr	ederick, Maryland						
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility BA	ST-STAUFFE	R FUNERAL HOME						
	Paul M. Dean 7	606 Old National P	ike, Boons	boro, MD 21713						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
		a. Urinary tractingeen on Onset and								
	resulting in death) Due to (or as a consequence of):	Due to (or as a consequence of): Coronaly artery disease								
<u></u>		b								
nine	cause. Enter Underlying Cause (Disease or injury									
xai	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
dical Examiner	L d									
edi										
an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery						
sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year						
Phy	9 Li Unknowji		00 5:11							
þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?						
eted			1 ☐ Yes	2 No 3 Probably 4 🗖 Unknown						
ğ			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
ខ			performed?	death? lo 1 □ Yes 2 □ No						
Be	25. Was case referred to medical examiner? Hospital: Article 11 April 12 A	Othor	h (Check only one)							
5.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. ☐ ER/Outp	- Talkalang ita	ome 5 Residence 28d. Describe how inju							
tio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	200. Describe now inju	ary occurred						
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Ru										
Sert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	te)						
cal (29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or	th occurred at the time, date and place,	and due to the cause	(s) and manner as stated.						
ledi	one) and manner stated.									
2	29b. Signature and title of certifier	29c. License number	29d. D	Pate signed (Month, Day, Year)						
		1066116		3/5/09						
	30. Name and address of person who completed cause of death (Item 23a) (Type 365 MILL STREET Heigerstew)	Andale	eeb Ali,Mo							
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	- 1,5 878	,						
ar	FEB 0 9 2009 Server B.	Barre								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 2:15 AM Josephine Helen DeMaria 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Retirement Village Washington County Williamsport 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Director 165-14-0211 93 Pennsÿlvania Jan. 8,1916 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits r 28a-f show notified at Maryland | Washington County 1 ☐ Yes 2X No Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with n and Mental Hygiene. Is marked other than "natural", or Items 23a or raumatic event, the IM dr al Exminer must be I 21742 1175 Professional Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carlo Deserino Angelina Scoaler Deserino ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n any injury or other traun once. Elvira D. Lynn-daughter 13628 Overhill Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2-11-2009 4 ☐ Donation 5 ☐ Other (Specify) Bensalem, Pennsylvania 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tul if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

54-10

altimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

580 Northern

FEB 0 9 2009

31. Date filed (Month, Day, Year)

Medical

State

Registrar

Hagerstown Progistrary Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

mo

DOOG 3233

29d. Date signed (Month, Day, Year)

2-6-09

		-	101	artment of Health and M ertificate of Death	ental Hygiei Reg.	0000	05035	
Г	Division		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death	
Physician /Medical			EUNICE MAY DOOLING		020	1 2009	23:26 PM	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
	Funeral		PENINSUM REGIONAL MORAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Yes	NICIMIO 9. Birth	nplace (State or Foreign	
	Director		197–12–6003 1□ M 2X F 84 Yrs.	Months Days Hours Min.	(Month, Day, Yei 11/8/1924	Penr	nsylvania	
	pud *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	Aaryla f sho	ō		oodion			1 ☐ Yes 21X No	
	r 28a-	Directo	MD Somerset Pocomoke 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?	
	th with		32010 Rehobeth Road	21851		USA		
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White,		
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, in Medical Evaning ruttle mailfud at	by F	1 □ Never Married 2 🔀 Married 1 □ Yes 2 🛣 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐Yes 2★☐ No Specify:		Specify:	vhite	
Maryland 21215-0036	2 hou atura		15 Decedent's Education 16a, Dec	edent's Usual Occupation	16b	Kind of Business/Ir		
218	thin 7 ne. nan "n	Completed	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workin DO NOT use retired)	9			
2	filed wi Hygier ther th			gement	/Fi	Retail		
anc	0 7 5	Be c	17. Father's Name (First, Middle, Last)		(First, Middle, Maio	en Surname)		
Ž	12 should be f h and Mental I 7 is marked of traumatic eve	ပ္	Robert Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mail	May Bent	_	v or Town, State, Z	ip Code)	
	and 2 sealth a n 27 is		James L. Dooling, Jr. (husband) 3201	,			,	
ore.	es 1 a of He of He if Item		20a Mathad of Disposition 20h Place of Disp			Location - City or T	own, State	
Ĕ	Pages tment of tant: If it jury or o		4 Donation 5 Other (Specify) Foisopal C	emetery 2/5/20	09 Poo	comoke Ci	ty, MD	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Holloway Funeral Ho 03 Linden Ave., Po	me, Profes comoke Ci	sional Asso ty, MD 21	ciation 1851	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
A.	Physician	Immediate Cause (Final disease or condition resulting in death) a. JEMENTIA						
	/Medical Examiner	Examiner	Due to (or as a consequence of):					
			Sequentially list conditions, if any, leading to immediate b					
	cuted nd ransit		Cause (Disease or injury that initiated events					
Ö,	icate be executed physician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d					
Box			IF FEMALE: 23b. Was decedent pregrant 23c. If yes, outcome of pregnancy			23d. Date of deliv	verv	
	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year	
<u>Ч</u>	at the I by th	hys	9 Unknown					
Š,	uires that the de signed by the a d be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to 2 ☐ No 3 ☐ Pro	the cause of death?	
Š	w requir s been s should	eted	- WINTING WIND					
Records,	The law cate has page 2 s	Completed by			24a. Was an autopsy performed	prior to co	topsy findings available ompletion of cause of	
Vital			25. Was case referred 6 medical	26. Place of Death	(Check anly one)		2 □ No	
	ys diris	o Be	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatie	Othor:	· · · · · · · · · · · · · · · · · · ·	6 ☐ Other (Spec	eify)	
Division of	ding Ph h. After th funeral	L:uo	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at 2 Work?	8d. Describe how in	jury occurred		
<u>S</u>	ttendl Jeath. tor: /	cati	2 Accident investigation	M 1 □Yes 2 □No	06 1 10			
2	al or Attendir s after death. I Director: Ai d in by the fu	Certification: To	determined determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, St	and Number or Rui ate)	'al Houte Number,	
	To the Hospital of within 24 hours af To the Funeral Discompletely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.	
	the Ho nin 24 the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre				
	Vitl Con	Ž	29b. Signature and title of certifier	29c. License number		Date signed (Month,		
			30. Name and address of person who completed cause of death (Item 23a) (Type	1 605/S		4140	7	
1	8A 3		W.THIMMARAVAPIA 614 B F	D 60515 KTEKN SHONE D	R 541	ICBURTA	121804.	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	11/1	211-1-120		
	Registr	ar	FEB 0 5 2009 Drum B.	arke				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 01:00 A M JANUARY 28, 2009 MAURICE B. K. EDMEAD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONGOMERY SHADY GROVE HOSPITAL ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Director 578-52-7249 MARCH 31, 1938 WASHINGTON, DC 70 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1.□Yes 2□No Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner nust be notified at Director MD MONGOMERY ROCKVILLE 10g. Citizen of What Country? 10e Street and Number 14524 WOODCREST DRIVE 20853 USA Funeral 12. Was Decedent Ever in U.S. Asped Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: A RMY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify. 3 ☐ Widowed 4 ☐ Divorced **BLACK** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) COMPUTER ANALYST MONTGOMERY COUNTY GOV. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAURICE EDMEAD ANNA MAE CHAPMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health WILLIAM F. EDMEAD--BROTHER 4926 CENTRAL AVE., N. E. WASHINGTON, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-21-09 LINCOLN MEMORIAL CEM. 4 ☐ Donation 5 ☐ Other (Specify) SUITALND, MD 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH.. DC 20002-5236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the de and shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final SMALL CELL LUNG CANCER **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, adding to improve the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 🗔 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. veral Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 67593 JANUARY 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZEWDIE, MD 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD WUBNEW

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) FEB 0 3 2009

1XYes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Black 16b. Kind of Business/Industry Superior Court Stewart 20c. Location - City or Town, State Beltsville, MD

05037

3. Time of Death

Birthplace (State or Foreign Country)

Washington DC

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

12:46a M

9 Unknown

d					
230	. If yes,	outcome	of p	regnar Fetal	ncy death

4 Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

23b. Was decedent pregnant in the past 12 months? ☐Yes 21 No

for use as

page 2 should be detached

filled in by the funeral

within 24 hours a

To the Funeral D

Completed by

Be

Certification: To

Medical

State

Registrar

P.0.

of Vital Records,

Division

1 - State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2**X**N0 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier

6 Could not be determined

D58957

29c. License number

29d. Date signed (Month, Day, Year) February 2, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gary Little 3001 Hospital Drive, Cheverly, MD 20785

31. Date filed (Month, Day, Year)

FEB 04 2009 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 8, 4:20 A M FEBRUARY BERNARD FRANKLIN ELBURN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OUEEN ANNE'S CENTREVILLE HOSPICE OF QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F 6/3/1943 MD 65 214-36-6039 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director KENT ROCK HALL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21661 **USA** 5672 MAIN ST. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ∐Yes 2 ∑XNo 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAFOOD 8 WATERMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELLEN CANNON GEORGE CLEVELAND ELBURN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5672 MAIN ST. ROCK HALL, MD 21661 LINDA C. ELBURN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/13/09 ROCK HALL, MD WESLEY CHAPEL 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Recurrent Don Small Coll 8 cms Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Squainoiss Cell Skin Candon 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 28 No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospico 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Box 68760, Division of Vital Records, P.O.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages
Department of
Important: If It
any Injury or o

Physician

/Medical

Examiner

within 24 hours at To the Funeral D 0

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D0050996

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) 05039 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year IASON 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 1**X**M 2□ F Months Days Min. 218-11-0836 Yrs. 22/1984 MD Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ Xlo OUEEN ANNE'S SUDLERSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 110 MILLER ST. 21668 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TREE CLIMBER LANDSCAPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RICHARD HUGH ELLIS JEANETTE COTHIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD H. ELLIS/FATHER 33570 GOLTS RD. MASSEY, MD 21650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/09 SUDLERSVILLE CEM. SUDLERSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS HELFENBEIN CYPRESS ST. N & NEWNAM F MILLINGTON, 23a. Part 1. Enter the discase, or or plication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one or ise on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN Due to (or as a consequence of): BRAIN ANGING Due to (or as a consequence of)

Physician /Medical Examiner

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Examiner must be notified at

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and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

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10a State

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is introduced to the control of the control that initiated events resulting in death) Last

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BERILLO	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No

Physician/Medical Examine

Completed by

Be

Medical Certification: To

Hospital:

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No

Year

1XYes 2 □ No 27. Manner of Death 1 Natural

2 Accident

3 Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 Could not be

determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 01-28-2009 23:00 PM

Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 110

Other: 4 Nursing Home

28d. Describe how injury occurred went inte hung him self with Abell

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) //O Millers 57 SUDLERS VILLE, MD 21668

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MI

NPI 1437/30184

29d, Date signed (Month, Day, Year) 01-30-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50

BULTIMORE, MI)

me State Registrar

31. Date filed (Mor

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	deat ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin?	(Specify Yes or N	0-	14. Race - Ai Black, Wi	merican Indian,	_
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σ.	that the poly detact		Part II. Other significant conditions	contributing to death bu	t not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
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	the thin 2 the the thin 2 the the thin 2	Medical	one) 29b. Signature and title of certifier	and manner sta	ted.		29c. Licens	e number		29d. D	ate signed (Mo	onth, Day, Year)	
	viii Cor			1000		D		51897			1/29/2		
	10+1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, F	Print)				-1-712		_
12	. (Niideka Udochi					11100++	City M	ח 21	042		

DHMH 17 Rev 1/2001

State Registrar

4b. City, Town, or Location of Death

Fort Washington if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 2. Date of Death

January

8. Date of Birth (Month, Day, Year)

22, 2009

4c. County of Death

June 28, 1913 Washington, DC

10g. Citizen of What Country? United States Race - American Indian Black, White, etc.

20c. Location - City or Town, State

Prince George's

22:30

Birthplace (State or Foreign Country)

10d. Inside City Limits 1x Yes 2 □ No

Month

	and w		10a. State	10b. County		10c. City,	Town or Locati	on							10d. lns
	sho sho	ь	Maryland		George's	T	emple H	ills							1 x
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	death with the Maryland ims 23a or 28a-f show r must be notified at	급		ckey Ave	nue				0748				Uni	ted	States
	eath is 23 must	Funeral	11. Marital Status		12. Was Decedent B	ver in U.S	S. 13. Wa			anic Origin? (Mexican, Pue	Specify	Yes or No-		Race -	American Indi
	ter d	F		ied 2□ Married	Armed Forces? 1 ☐ Yes 2 🔯 N If Yes, Give						rto Rica	ın, etc.)			White, etc.
336	urs af al", or Exami	by	3 X Widowed		If Yes, Give Year or Dates:		1	Yes 2	XI No S	Specify:			Sp	ecify:	Black
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	(Spec	15. Decedent's E cify only highest g	Education rade completed)		16a. Deceden	t's Usual d of work	Occupation done duri	on ing most of w	orking		16b. Kind	of Busi	ness/Industry
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0 4	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Dear	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		Bc. Injury a Work?		28d	. Describe	how injury o	occurre	d
<u></u>	endl sath. or: A he fu	äţic	2 Accident	investigati	ha			М		es 2 No					
Division or Vit	or Att fter de Directe n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine				t, factory,	office		28f.	City or To	Street and wan, State)	Numbei	or Rural Rout
	pital urs a eral L		20a Cortifica	1 Cartifuina	Physician: To the best	of my kno	wiedne death	ocurred s	at the time	. date and nla	ace, and	due to the	cause(s) a	nd man	ner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)	2 Medical Ex	aminer: On the basis of and manner st	of examina	tion and/or inve	stigation,	in my opi	nion, death o	ccurred	at the time	, date and p	lace, ar	nd due to the o
	o the o the o the o the o the ompl	Me	29b. Signature and	d title of certifier				29c.	. License i	number			29d. Date	signed	(Month, Day,
-	- s - o		1 1		410		_	1.0			1	,	4		201

1. Decedent's Name (First, Middle, Last)

Ρ.

6 Sex

1 □ M 2 🛣 F

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

Ford

7. Age (In yrs. last birthday)

95

Yrs.

Corretta

Social Security Number

578-07-6410

Physician

/Medical

Examiner

Funeral

Director

:009 Landover, MD Funeral Home, Inc. shington, DC 20019 Approximate Interval Between Onset and Death orv arrest. 23d. Date of delivery Year Month Day Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ 'No Was an autopsy performed? Yes 2 No only one) Residence 6 Other (Specify) cribe how injury occurred 1 ☐ Yes 2 ☐ No M 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 1-23-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FT. WASHINGTON MD 20744 HUIZDWIVI.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

FEB 0 3 2009

			For State Registrar	State	of Marylan	-			d Mental Hy	_	000	05012
	-			(act)		Cei	rtificate of I	Death	0.5.4.5	Reg. No	009	05042
	Physici	an	1. Decedent's Name (First, Middle,						Date of De Month	Day	Year	3. Time of Death
4	/Medic		Leo James Fitzgo						JANA		2009	3-25 PM
).	Examin	er	4a. Facility Name (If not institution,	give street and ni	imber)		4b. City, Town, or		leath	4c. Co	ounty of Death	
		Page 1	Levindale 5. Social Security Number 6	S. Sex	7. Age (In yrs. I	ast hirthday)	Baltimo:	re If Under 24	Hrs. 8. Date of Bi	dh	O Bigh	-1 (0)
	Funeral Director		578-42-0946	1⊠M 2□F		Yrs.	Months Days		Min. (Month, Da	a <i>y, Year)</i>	9. Birth Cou	
	-		Usual Residence of Decedent		76				11/29,	1932		DC
yland	at		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Mar	a-f sl	ior	MD Anne An	cunde1		Churc	hton					1 □ Yes 🍇 No
th the	or 28 e not	jre(10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?
th wi	23a d] le	5558 Franklin B	Lvd.				20733		U	SA	
r dea	ems er mi	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.s	S. 13. \	Was Decedent of Hi	ispanic Origin'	? (Specify Yes or No uerto Rican, etc.)	o- 14	Race - Ameri	
d 21215-0036 Illed within 72 hours after death with the Maryland	or it	y Ft	1 ☐ Never Married 2 Marrie	d 1 ∏ Yes If Yes, G	2□ No live Dates: 51 —		I □ Yes 2፟፟⊠ No	Specify:	and thousand order)			√hite
on is	ural"	d by	3 ☐ Widowed 4 ☐ Divorced		Dates: JI							
21215-0036 ed within 72 hours af	"nat	Completed	15. Decedent's (Specify only highest	grade completed,	1/4	16a. Deced	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of	working	16b. Kind	of Business/In	dustry
with 2	than he M	E C	Elementary/Secondary (0-12)	College ((1-4or 5+)	Plum		,		D1	mbing	
D ==	other ent, the	ပ္	17. Father's Name (First, Middle, La		l	1 1 011		18. Mother's	Name (First, Middle			
Maryland	or results and welvalent hygelical and them 23a or 28a-f show them 21s marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	Leo J. Fitzgeral	Ld					n Crown	,	,	
shou	mar	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a		r Rural Route Numb	er. City or T	own. State. Zir	Code)
7e, Mg	27 Is		Virginia Fitzger	ald Wif	· _		Franklin					
5 - S	othe		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of natory or other plac	DTATE	Churcht Date	20c. Locat	1 20733 tion - City or To	own, State
Pages	ır ir i	ı	1√Burial 2 □Cremation 3 4 □Donation 5 □Other (Spe		State		1n Cemete		30/2009	Bront	wood, M	m
altimore,	= = =		21. Signature of Funeral Service Li						ardesty F	unera	Home.	P. A.
m § a	Important Ir		175 J. Ch						Annapolis			1
	137		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that	caused the death							Approximate Interval Between
Phy	sician	1	Immediate Cause (Final disease or condition		RONAR		RTERY		SEASE		4	Onset and Death
	ledical		resulting in death)	Due to	(or as a consequ				20,700		-	
EX	aminer		Sequentially list conditions	b								
D	#	Examiner	Sequentially list conditions, it also be a leading cause. Enter Underlying Cause (Disease or injury that initiated events	Districts	(Ur as a noneequ	ence off						
ecute	and trans	cam	that initiated events resulting in death) Last	c								
8760, cate be executed	cian a		, and a second s	Due to	(or as a consequ	ence of):						
87 cate	physician and s the burial-transit	dical		d								
X 6	attending for use as	Physician/Me	IF FEMALE:	23c If yes ou	tcome pf pregnar	acv						
. Box 6	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 ☐ Fetal nant at time of de	death 3	Ectopic pregnancy Other (specify)			23d	 Date of deliver Month 	ery Day Year
j å	by the a	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn		raui 5	Other (specify)					
J ta			Part II. Other significant condition	s contributing to d	eath but not resul	Iting in the un	derlying cause give	n in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
Kecords, he law requires t	n signe	d by	SEPSIS						1 🗆 '	Yes 2	√o 3∐ Prob	ably 4 □Unknown
S §	s been si	Completed	END STAG	IE RI	ENAL	Dis	EASE		24a. Was	an o	Mb. Mora auto	more finalização acreitable
Fe le	e has	E I			LLAT				- autor	psy ormed2	prior to con death?	psy findings available mpletion of cause of
			25. Was case referred to medical		CCT (FOIL		Of Disease of D	1□ Yes		1 ☐ Yes	2 □ No
	.o =	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2 ☐ E	ER/Outpatien	3 DOA Othe		Death <i>(Check only c</i> g Home 5 ☐ Resi		7045	
g Phy	두 교	盲	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injury Work		28d. Describe			<u> </u>
UIVISION I or Attending	or: Af	atio	14⊒Natural 5 Pending 2 Accident investigat	ion	nth, Day Year)	Injury		? ′es 2 □ No				
Z Att	Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place	of injury - At hor ing, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and N	lumber or Rura	I Route Number,
ital o	ral D	ਲੁੱ										
Hosp 4 hou	ely fil	edical	(Under only Z Medical E)	Physician: To the taminer: On the b	e best of my know easis of examinati	ledge, death	occurred at the time	e, date and pl	ace, and due to the ccurred at the time,	cause(s) an	d manner as s	tated.
To the Hospital or At within 24 hours after d	To the Funeral Direc	Medi		and man	ner stated.				-consecute unle,			, are cause(s)
O #	2 0	-	29b. Signature and title of certifier		N		29c. License		3		igned (Month,	,
5+	1		pluson 11 1					5332	/	Jan-	26,2	-009
2 L	5		30. Name and address of person wh							0.00	- 4	
			GIZAW WOLDE	77 (WU)	gistrar's Signatu	アンナ バ	1. DELVE	DERE	AVE, E	ATLTIN	NURE,	110 21215
	ِ Stat Registra	ar_	31. Date filed (Month Day Yay)	2009	MELLA .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28,2009 Year **Physician** 6:45amM Fife January Barbara /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Heritage Harbour Health and Rehab Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 3/25/25 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days Hours Min 1 ☐ M 2 🙀 F California 050-22-7267 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the "Motical Examiner must be retified at 1 ☐ Yes 2 ☐ No Funeral Director Anne Arundel Harwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3851 Solomons Island Road 20776 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ray any Injury or other traumatic event, the Modore. Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Hendricks James Fife ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3851 Solomons Island Rd. Harwood, MD 20776 Donald Wootten 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/30/2009 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death tout Immediate Cause (Final **Physician** OCKIO C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Que to (or as a nonsequence of) Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a □Yes 2 ☑No g Unknow 23e. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to d Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 1 □Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Ampletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the within 7 29d, Date signed (Month, Dav. Year) 29b. Signature and title of continue 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

			1 - For State Registrar	State of Maryland /		rtificate of		a Mental Hy	ygien Reg.	2009	05044
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of D Month	eath	ay Year	3. Time of Death
	/Medic		Virginia L. Fi					Janua	ary	23 200	9 12:50A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		eath	4	c. County of Dea	
-	Funeral		Caroline Nursi 5. Social Security Number 6. S		irthday)	Dento	If Under 24 I	Hrs. 8. Date of B	irth	Caroli 9. Bi	
4-	Director		213 11 3010	□M 2 X F 86	Yrs.	Months Days	Hours M	Min. July	8 1	922 Ma	rthplace <i>(State or Foreign</i> Jountry) . ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Lo	ocation					10d. Inside City Limits
	Maryl f sho	tor	Maryland Anne A	rundel Ann	apo	lis					1X Yes 2 No
	h the or 28a e notii	Director	10e. Street and Number			10f. Zip Code			10g. C	citizen of What C	ountry?
	23a c ust be	ral D	2044 Gate Dr.			2140	1			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Maritai Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Am Black, Whi	
Maryland 21215-0036	2 hour atural cal Ex	ted	15. Decedent's Ed	ucation 16a	a. Dece	dent's Usual Occup	pation		16b.	Kind of Business	
215	thin 7, ie. ian "n Medi	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			
2	filed wi Hygien sther th		8th	0	_Da	y Care				1f Emp	loyed
ano	d be fi	Be C	17. Father's Name (First, Middle, Last) Wilmer Stanfor	ď				_{Name (First, Middle} nder Tur	,	,	
Z Z	2 should and Men is marke aumatic	은	19a. Informant's Name/Relationship (b. Maili	ng Address (Street		r Rural Route Num			Zip Code)
	1 and 2 Health a em 27 is		Clementine Joh			044 Gat				, Md.	
Baltimore,	Pages 1 and the neut of He int: If item		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □	Bemoval from State 20b. Place of cemeter	of Dispo ery, crei	sition (Name of matory or other pla	ce)	Date	20c. l	Location - City or	r Town, State
E	t. Pag tment tant: ijury o		4 ☐ Donation 5 ☐ Other (Specify) Spr		Grove		-30-09	1	nton,	
Ba	permit. Departr Imports any Inji		21. Signature of Funeral Service Licer	NW483	8	21 West	St. A	ons Mort Annapoli	s,		
			23a. Part1. Enter he disease, or com shock, or heart failure. List only Immediate Cause (Final	olications that caused the death. Do one cause on each line	not ent	er the mode of dyi	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due to (or as a consequence	VE	nti	3				years
	Examiner				: OI).						C
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):						
	rificate be executed g physician and as the burial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	000:						
90	be e)				oij.						
68760	# D #	edical		.d							
Box	attending for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3Г	Ectopic pregnanc				23d. Date of de	elivery
о. Е	The law requires that the death cer the has been signed by the attendir age 2 should be detached for use	by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown		Other (specify)	y 			Month	Day Year
٦.	ires that the de signed by the a I be detached f	Ph	Part II. Other significant conditions of	ontributing to death but not resulting	in the u	nderlving cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
Records ,	uires sign	d b				, , ,				4.4	robably 4 Unknown
Ş	aw requires been signal should t	olete					-	24a. Was	s an	24b. Were a	utopsy findings available
		Completed							opsy formed? 2 X N	death?	completion of cause of s 2 □ No
VItal		Be	25. Was case referred to medical examiner?					Death (Check only			
ō	Phys this al dii	ို	1 Yes 2 Nanner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatier		4 Nursin	g Home 5□ Res			ecify)
0	ding fh. : After funer	tion	1 Natural 5 Pending 2 Accident investigation		Injury	Wor	yat k? Yes 2∐No	28d. Describe	now inju	ury occurred	
DIVISION	after death after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, str			28f. Location	(Street a	and Number or R	ural Route Number,
5	Hospital or A	Ser						City or To		,	
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my knowledg iner: On the basis of examination a and manner stated.	e, deatl nd/or in	n occurred at the til vestigation, in my o	me, date and piopinion, death o	ace, and due to the occurred at the time	e cause(s e, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	Vi MA		29c. Licens	e number	-51	29d. Da	ate signed (Mon.	th, Day, Year)
)	- Lox)		or ru		000	PHIS	54		112	3/09
4	Segan J		30. Name and address of person who	completed cause of death (Item 23a)	(Type,	Print)	inton 1	nd 711	629		1
	0.	te	31. Date filed (Month, Day, Year)	32, Registrar's Signature	- 1	or N	1101/1	14.	061		

Registrar

JAN 3 0 2009

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artment of Health and Mental H	ygiene C C C	OFOLE
artment of Health and Mental H ertificate of Death	Reg. No. 2009	03043

Physician	
/Medical	
Examiner	

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar	i Maryland / L		ate of Dea			Reg. N	/ 11 1 4	05045	
an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month 1/21/2	ath D	ay Year	3. Time of Death	
cal	LOIS MAXINE GARDNER 4a. Facility Name (If not institution, give street and nu.	mher)	4h C	ity, Town, or Locati	on of Death	1/21/2		C. County of Deat	7:02 p M	
ier	Prince George's Hospital			Cheverly	on or beaut			Prince Ge		
П	5. Social Security Number 6. Sex	7. Age (In yrs. last birt		der 1 Year If Un	der 24 Hrs.	8. Date of Bir (Month, Da 5/13/			hplace (State or Foreign	
	579-50-0177 Usual Residence of Decedent	72	Yrs.	lo Days 1100	IVIIII.	5/13/	1936	Lou	isa, VA	
	10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits	
ctor	Maryland Prince george's	Lanham							1 ⊠Yes 2 □ No	
Dire	10e. Street and Number		10f.	Zip Code			10g. C	itizen of What Co	untry?	
rai	9108 91st Place			20706				ted Sta		
Funeral Director	11. Marital Status 12. Was Dece Armed Fo 1 ☐ Never Married 2 ☐ Married 1 ☐ ☐ Yes		13. Was De	ecedent of Hispanic specify Cuban, Mex	Origin? (Sp ican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White		
by	3 ☑ Widowed 4 ☐ Divorced Year or D	ve	1 □Ye:	s 2⊠No Spe	cify:			Specify: Bla	Lack	
Completed by	15. Decedent's Education (Specify only highest grade completed)	Kind of Business/	Industry							
Id m	Elementary/Secondary (0-12) College (1									
ပိ	17. Father's Name (First, Middle, Last)	overnmer n Surname)	10							
To Be	Julian Pettit Johnson	,								
	19a. Informant's Name/Relationship (Type. Print)	or Town, State, 2	Zip Code)							
	Michael Nukols / Son			Guffey Ct	. Wood	lbridge				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State 20b. Place of cemeter	Disposition (y, crematory	Name of or other place)	!	Date		_ocation - City or		
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licersee	Harmon	y Memo					dover, N		
	With G. Janas	lomes, P. e, Maryl	.a. Land 20747							
	23a. P.: 1 = 1 er the disease, ir complication that of shock, or heart failure. List only one cause on e	caused the death. Do reach line.						***	Approximate Interval Between	
	Immediate Cause (Final disease or condition	SATIC RECTA	AL CAR	CINOMA					Onset and Death	
	resulting in death) Due to	(or as a consequence of	of):							
Jer	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of	of):							
amir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
Medical Examiner	resulting in death) Last Due to	(or as a consequence of	of):							
gdic	d									
		tcome of pregnancy						23d. Date of del	ivery	
Physician/I	1 ☐ Yes 2 ☐ No 4 ☐ Preg	birth 2 ☐ Fetal death nant at time of death nown	5 ☐ Other	ic pregnancy (specify)				Month	Day Year	
Phy	9 Unknown Part II. Other significant conditions contributing to de		the underlyin	ra causa given in Pr	net I	230 Did t	obacco	ueo contributo to	the cause of death?	
Completed by	Trait is other agrinicant conditions continuing to di	eath but not resulting in	the underlyin	ig cause given in Fa	aiti.				obably 4X Unknown	
lete						24a. Was			itopsy findings available	
ошр						autoj perfo	osy rmed?	prior to death?	completion of cause of	
BeC	25. Was case referred to medical examiner?			26. P	lace of Deat	1 ☐ Yes h (Check only o	71	o Thes	2 □ No	
	1 Yes 2 XNo Hospital: 1 X		tpatient 3		Nursing Ho	ome 5 ☐ Resi	dence	6 ☐ Other (Spe	cify)	
tion:	- Lander and - Lan		Time of njury M	28c. Injury at Work? 1 □ Yes 2		28d. Describe	now inju	ury occurred		
fical	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, far			-	28f. Location (Street a	and Number or Ru	ural Route Number,	
Certi	4 ☐ Homicide determined buildi	ing, etc. (Specify)				City or To	vn, Sta	te)		
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the (Check only one) The Medical Examiner: On the band man	e best of my knowledge pasis of examination an ner stated.	e, death occur d/or investiga	red at the time, dat tion, in my opinion,	e and place, death occur	and due to the red at the time,	cause date a	(s) and manner as nd place, and due	s stated. to the cause(s)	
Me	290. Signature and the of certifier			29c. License numb	er		29d. D	ate signed (Monti	h, Day, Year)	
) I w	NO		D552	3		0	1-21-	09	
	30. Name and address of person who completed cause	se of death (Item 23a) (
	TERRI MATIN MD 3001 Hos	pital Driv	e Che	verly, Ma	ryland	d 20785				
ite rar	FEB 0 2 2009 Januar)	Registrar's Signature								

09-01126 Sheila Gibson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of M	Certific	cate of Death		Reg.	No. 201	<u> </u>
Physician al Examine	/ 1	Decedent's Name (First, Middle,Last) Sheila M.	Gibson		1.5	2. Date of Death Month February 5,	ay Year	3. Time of Death 0909 hrs
ai Examine		a. Facility Name (if not institution, give street		4b. City, Town	n, or Location of Death		4c. County of Deat	
,		Southern Maryland Hospital		Clinton	, i.,	To Division of Division	Prince Georg	
Funeral Director	- 1	Social Security Number 6. Sex	7. Age (In yrs. last bi		Year If Under 24Hrs Days Hours Min.		955 Che	ountry) ever1y, MD
any	-	sual Residence of Decedent 0a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
*		MD Prince Geor	ge's Suitla	and				1 X Yes 2 No
the Maryland a or 28a-f show iified at once.		0e. Street and Number		10f. Zip Co	de	10g	. Citizen of What Cou	intry?
3a or 3		4653 Lacy Avenue		2074			nited Stat	
or items 23a or 28a-f sho must be notified at once.	unera	Never Married 2 X Married 1	Vas Decedent Ever in U.S. urmed Forces? Yes 2X No	If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto		White, etc.	rican Indian, Black,
ral", o		Widowed 4 Divorced If Yes, or Date	Give Year	1 Yes 2 X	No specify:	work done	Specify.Whit	
2 hour "natu	Completed	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	ollege (1-4 or 5+)		g life. DO NOT use reti		Domestic	
wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Ę	7. Father's Name (First, Middle, Last)	inc	Sitema.ver	18.Mother's Name	e (First, Middle, Ma		
Mental H marked o	e R	William T. Matting1			Edith P			
Pages 1 and 2 should be figure to Health and Mental I faut: If item 27 is marked or other traumatic event,	- 6	9a. Informant's Name/Relationship (Type, Pr Michael Gibson (Se		19b. Mailing Address (e, Zip Code)
l and 2 sho Health and item 27 is r traumati	- 1-	Oa. Method of Disposition	20b. Plac	e of Disposition (Name			20c. Location - City of	r Town, State
permit, Pages I and Department of Heal Important: If iten injury or other tra	1	1 Burial 2 X Cremation 3 Re		natory or other place) Lincoln Cr	ematory1/1	3/2009	Brentwood	MD
mit. P		Donation 5 Other Specify: 1. Signature of Funeral Service Licensee		22. Name and Ad	dress of Facility Fo	rt Linco	In Funeral	Home
Der Im		Lund Thomy I			adensburg			ID 20722 Approximate Interva
hysician Medical	1	23a. Part I. Enter the disease, or complication failure. List only one cause on each line	э.		lying, such as cardiac o	or respiratory arres	st, snock, or neart	Between Onset and Death
caminer			nplications o (or as a consequence of):	f sepsis	- in	10		
		Sequentially list conditions, b.						4
	히	f any, leading to immediate Due to	(or as a consequence of):					
	E	(Disease or injury that initiated events resulting in death) Last	(or as a consequence of):					
	×			07 107	C890 4/23	09 TT		
	ώ	d	23a.PII.	フ/.ner ME.				
- 1	dical	d. X UNPENDED X AME	6,19a per	2/,per ME, r fh g893 7	-1-09 vt		23d. Date of delive	erv
	edical	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c	ENDED 23a,PII, 6,19a per 6,19a per 10. If yes, outcome of pregnan Live birth Pregnant at time of death	2 Fetal death	3 Ectopic pregn		23d. Date of delive Month	ery Day Year
	sician/Medical	F FEMALE: 33b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 9	c. If yes, outcome of pregnan Live birth Pregnant at time of death Unknown	2 Fetal death 5 Other (Specify	3 Ectopic pregn	ancy	Month	Day Year
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law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial transit	Completed by Physician/Medical	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions control Hypertesnive ather	c. If yes, outcome of pregnan Live birth Pregnant at time of death Unknown ibuting to death but not resul	cy 2 Fetal death 5 Other (Specify Iting in the underlying ca ardiovascu	3 Ectopic pregn	23e. Did tot 1 Yes 24a. Was a autops perfor 1 Yes	Month pacco use contribute 2 No 3 Pr n 24b. Were prior to death?	Day Year to the cause of death? obably 4 Unknown autopsy findings availab o completion of cause of
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09-00887

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Takako Gilmore 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gilmore 1117 hrs **Medical Examiner** Takako January 30, 2009 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2100 Brooks Drive #603 Forestville Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours February 11,1930 Japan Director 558-21-7886 78 M 2 X F Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show is 23a or 28a-f shov se notified at once. Forestville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country USA 20747 2100 Brooks Drive #603 ₫ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? White etc. 1 Never Married 2 Married Yes Asian 4 X Divorced Yes, Give Year Yes 2 X No specify: Specify Widowed other than "natural". à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) vernit. Pages 1 and 2 should be filed within 72 hour epartment of Health and Mental Hygiene.
portant: If item 27 is marked vry or other trans pleted Library of Congress Elementary/Secondary (0-12) College (1-4 or 5+) Foreign Language Translator Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Gilmore Weir - Niece 12216 GuinevereRd., Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Burial 2 X Cremation 3 crematory or other place) Feb. 3, 2009 Edgewater, MD Kalas Crematory Donation 5 Other Specify 21. Signature of Funeral Service Ligense 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon HillRd., Oxon Hill, MD 20745 23a. Paker. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed transi and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 ned by the atte detached for u 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) director. Be Other₄ examiner? Hospital: DOA this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 1 V Yes funeral 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural within 24 hours after death. To the Funeral Director: Pending Yes 2 I Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide filled determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 31, 2009

OCME

Margarita Korell MD. 31. Date filed (Month, Day, Year) State

32. Registra 's Signature

who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05048 State of Maryland / Department of Health and Mental Hygiene? [] [] 9 For State Registra MFND#1perMD 2-4-09, BMV, MOO Certificate of Death 1. Decedent's Name (First, Middle, Last) Duraiswami 2. Date of Death 3. Time of Death Guruswami Day **Physician** Month Year 058 AM OI 25-2009 /Medical WUS WAM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cinilers it of MINRY LAND Medical Contes.

5. Social Security Number 6. Sex 17 Age (1917) Date of Birth 4 93 6 **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F 212-63-7338 72 India Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f shover must be notified at Howard MD Highland 1 □Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6800 Koandah Gardens 20777 India 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 □Yes 21 No Asian Completed by Specify. 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Modical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Paper 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be D.V.Guruswami Dharmambal unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6800 Koandah Gardens Highland, Md 20777 Girija Duraiswami/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. 20a. Method of Disposition Pages 1 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1/26/2009 Beltsville, Md 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licen PHYTE TO Address RINALDI FUNERAL SERVICE, P. A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Acinetopacker PARLIMONIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year P.O. E 5 Other (specify) □Yes 2 111No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Spivision of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performer certificate 1 ☐ Yes 2 W No 1 ☐ Yes 2 MNo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐Yes 2 ☐No after death | Director: / d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number MD 145 748 1947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wermine, MD GREEN ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04

State of Maryland / Department of Health and Mental Hygiene 2009

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 1645 HOLLEY ancia 2009 SANDRA MARTIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 71 HARRY S. TRUMAN DRIVE # 24 LARGO 8. Date of Birth (Month, Day, JUNE 16 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months 1 ☐ M 2 🖾 F NORTH CAROLINA 59 105-40-0690 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar must be notified at 14 Yes 2 No Director PRINCE GEORGE'S LARGO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20774 71 HARRY S. TRUMAN DRIVE # Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 □Yes 2 💆 No Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSIT. PRIVATE 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental h Be MELISSA P. ELLIOTT SHERMAN G. MARTIN ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1803 GENTRY LANE WEST PEORIA, ILL. 61604 of Health a item 27 is CHARLIE MARTIN/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEME2/10/2009 CHELTENHAM, MARYLAND 4 Donation 5. Other (Specify) 21. Signatur J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterioschenoti **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? /es 2 certificate 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¥∐Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) State FEB 0 4 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 19 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:01A.M January 27, 2009 Thomas E. Harris /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 12/12/1948 240-72-2788 60 NC Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Prince George's Forestville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 Funeral 2211 Ritchie Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Baltimore, Maryland 21215-0036 Specify: **Black** If Yes, Give Year or Dates: Specify: δ. 3 ☐ Widowed 4 Noivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Transportation Health and Mental Hygiene. em 27 is marked other than Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Charlie Ricks Cora Walters Pages 1 and 2 should I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau Sandra B. Harris/Former Spouse 2211 Ritchie Rd., Forestville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 12/3/2009 Suitland, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Serv 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Unknows **Physician** . /Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions, Due to or as consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical the as IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year o 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X**No certificate 2 1XN0 1 □Yes 1 □Yes I or Attending Physician: after death.
Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 **X**(No 1 ☐ Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Injury 1 Natural 2 ☐ Accident (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1.27.00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Georgia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FFR 0 4 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No.2009 05051 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:45 p M February 01 2009 Vivian A. Hanna /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Sunrise Assisted Living Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🖾 F Months Days Hours Min Director 85 May 02, 1923 District of Columbia 524-98-4291 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner hust be notified at 1 ☐ Yes 2 K No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20874 13244 Autumn Mist Circle U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No 2 Specify Specify: 3 ☑ Widowed 4 ☐ Divorced "natural" White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Charles W. Johnston Virgie Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Susan L. Chandler - Daughter 13244 Autumn Mist Circle, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 02/05/2009 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, o Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) End Stage Alzheimer with Failure to Thrive Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Years Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Degenerative Joint Disease Years Due to (or as a consequence of) Physician/Medical Anemia Year IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached it 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pacemaker, Gait Disorder 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perforn 1 ☐Yes 2 No vars after death.

eral Director: After this certifical filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) Assisted Living 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 😡 Natural 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatury 29c. License number D54749 February 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, M.D., 801 Toll House Avenue, D-1, Frederick, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

FEB 04

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

of Vital Records.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 31. 20009 BETTY MAE REPPERT HACKMAN 8:02 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT 402 OSPREY COURT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 1 □ M 2 □**X**F 84 210-12-9917 10/7/1924 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 OSPREY COURT 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, 1 ∐Yes 2 ∐XNo 1 Never Married 2 X Married

Physician /Medica

Examine

Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial-transit completely filted in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

	ð	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐Yes	2 [XN	Specify:			S	pecify:	WHITE	
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9	BeC	17. Father's Name (First, Middle, Last)					18. Mother's N	Name (Fi	rst, Middle, Ma.				
	0	HENRY WILLIAM RI	EPPERT				MINNI	E PH	HILLIPS				
	Ξ,	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Addr	ess (Stre	et and Number or	Rural Ro	oute Number, C	ity or T	own, State	e, Zip Code)	
		KATHERINE LEVENGO	OOD/DAUGHTER	92	255 UPI	PER C	REEK LN.	. CH	ESTERTO	νN,	MD 2	1620	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	emeter	Disposition (i	or other p	· '	Date				or Town, State	
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100	any	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ncy death	3 ☐ Ectopi	c pregna	ncv			23d. Date of delivery			
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Cortification: To	<u> </u>	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, fari	n, street, fact	ory, office		28f.	ocation (Stree	t and N	lumber or	Rural Route Number	r,
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M	M	29b. Signature and title of certifier	10				se number	- 0		Date s	igned (Mo	nth, Day, Year)	
		· StuA1	NV			1	00419	28	7	2	- / 2	2/09	
		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)							1	
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Amend PI PII per MD 8890 4/1/09 IT.

State of Maryland / Department of Health and Mental Hygiene

December Name Process Annual Supplement of Comment of				1 - For State Registrar		Oldio of N	iai yiaiia /		rtificate of		i wentan n		No.200	9	050	053
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Physician Medical Examiner Physician Medical Examiner 1	15-("natu	ete	(Spec	15. Decedent's ify only highest of	Education grade completed)	168	. Deced	lent's Usual Occup kind of work done	pation during most of w	orking	16b.	. Kind of Busine	ss/Indu	stry	
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Physician Medical Examiner Part Physician Physi	ä	and market		175	2.0	Jun-		1_	12 Ridge	ly Ave.	Annapo	Lios				
Transfer Children Tran				snock, or nea	rt failure. List on	v one cause on each	line			ng, such as cardi	ac or respiratory	arrest,			nterval Bet	ween
Secure ficially list conditions, secure figure to medical cause (blease or injury resulting in neath) Last Secure ficially list conditions, secure figure for the first of	1			disease or condition	Final n	_ a	MA CETT.	TH	ma Kemia						onset and L	Jeath
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The state of the s		ad sit	iner	Sequentially list cor if any, leading to im-	nditions, mediate rlying		s a consequence	of):						1		
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So was seederent pregnant in the past 12 months? In the past 12 mont	89	artifica ing ph e as th	Medi	IE EEMALE:					-						_	
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER AMY J. ZWETTLER LT MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Dİ	lor Att after d Direct I in by I	ertific	_		d 28e. Place of In	jury - At home, fa tc. <i>(Specify)</i>	ırm, stre	et, factory, office		28f. Location (City or To	Street wn, Sta	and Number or ate)	Rurai F	Route Numi	ber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMY J. ZWETTLER LT MC USN State 31. Date filed (Month, Pay, Year) 32. Fegistrar's Signature	_	lospita hours uneral		29a. Certifier (Check only	10 Certifying I	Physician: To the besi	t of my knowledge	e, death	occurred at the ti	me, date and place	ce, and due to the	cause	e(s) and manner	as stat	led.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMY J. ZWETTLER LT MC USN State 31. Date filed (Month, Pay, Year) 32. Fegistrar's Signature		the H thin 24 the F mplete	/ledi	0110)		and manner s	tated.				urred at the time					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMY J. ZWETTLER LT MC USN State 31. Date filed (Month, Pay, Year) 32. Segistrar's Signature		P ₹ P 8		290. Signature and	nie or certifier	2/90	-	M			(374)	29d. [Date signed (Mo	nth, Da	ly, Year))
AMY J. ZWETTLER LT MC USN State State AMY J. ZWETTLER LT MC USN BETHESDA MD 20889-5600 32. Fegistrar's Signature			-	30. Name and addre	ess of nerson an	completed cause of	death (Item 23a)	(Type 5					1/5	//	0,	/
State 31. Date filed (Month, Day, Year) 32. Segistrar's Signature		ردن						(1)0011						ENT	ER	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland 1 - State Registrar		artment of H rtificate of L			Jiene 1eg. No2 () () 9	05054	
			Decedent's Name (First, Middle, Last)			2. Date of Dea Month	144 0 0 0	3. Time of Death		
	Physicia /Medic		Bertie Glee Homan		I—————————————————————————————————————		Februa	ry 6, 2009		
	Examin	er	4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Dea			
	Funeral		St. Mary's Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Leonard	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day February		thplace (State or Foreign buntry) aska	
	Director		505 - 20 - 4332	Yrs.	Months Days	Hours Will.	February	8,1925 Nebr	aska	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits	
	Maryl I.f sho	tor	Maryland St. Mary's	Lexi	ington Pa	rk			1 □Yes 2 No	
	or 28e	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?	
	ath wi		22920 Bridlewood Lane	140	2065		acifu Von or No	USA 14. Race - Ame	origan Indian	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exportant into the coefficient once.	by Funeral	11. Marital Status 1 ☐ Never Married		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛣 No	Specify:	Rican, etc.)	Black, Whit	e, etc.	
215-0036	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ting	16b. Kind of Business	/Industry	
121	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Me.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired ident	0		Private Sc	hoo1	
d 21	filed v I Hygiv other ent, II	Be Co	17. Father's Name (First, Middle, Last)	1100	100.10	18. Mother's Nam		Maiden Surname)		
/lar	uld be Menta arked atic ev	To B	Bert Homan			Anna C.				
Maryland	2 sho h and r is ma		19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,		
	1 and 2 Health tem 27 other tra				osition (Name of matory or other place	1	Date	, Maryland 20 20c. Location - City or		
ē	Pages nent of I int: If Ite		11 Burial 2.000 Cremation 3 Li Bernoval from State 1		n Crematory		iary 1009	Alexandria, V	irginia	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Kanneth Phifer		2. Name and Addre			ardiner Funer and 20650	al Home, P.A.	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not en	ter the mode of dyir	ng, such as cordiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death) a	ence of):	ier C	1010	pu		W DOS	
	Examiner	L	Sequentially list conditions, b.	12/	man	ua ·			>19)	
_	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0,	icate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a conseque	ence of):						
68760,	cate b physic the bu	edical	d							
O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decent in the past 12 months in the past 12 m	death 3[☐ Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year	
9.	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not result	Iting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?	
rds	w requires been sign should be	ed by	1		A		1 🗆 Y	′es 2 🛭 No 3 🗆 F	robabiy 4 ☐ Unknown	
of Vital Records,	The law requisate has been page 2 should	Completed	Coronary Antery E Hy	PERLEY	en End	Ramalose	24a. Was a autop perfor 1 □ Yes	rmed? death?	utopsy findings available completion of cause of s 2 □ No	
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1	- J	at 3 🗆 DOM Oth	26. Place of Dea				
o	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury 2	28b. Time o	III 3 1 100 1	y at		dence 6 Other (Sp. now injury occurred	эспу)	
ion	ending Fath. or: After he funer	atio	2 Accident investigation	iiijui y		Yes 2 □No				
	- 0	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	me, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	ural Route Number,	
	To the Hospital or Attending Physician: The within 24 hours effect death. To the Funeral Director: After this certificate h completely filled n by the funeral director, page	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner states.	vledge, dea ion and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the erred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)	
	To the within comp	Me	29b. Signature and title of certifier	2-1	29c. Licens	se number	9	29d. Date signed (Mon	th, Day, Year)	
			Germent fest	2201	Drint)	0641	1	2-8	01	
ملل			30. Name and address of Jarnes P. Jarnes P. Jarnes M.D. 24035 Arree N			ood, Marvla	and 20636			
	Sta		31. Date filed (Month, Day, Year) 32. Rehistrar's Signatu		6-41					

09-01139 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Heyer State of Maryland / Department of Health and Mental Hygiene 2009 05055 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard Heyer **Medical Examiner** 2029 hrs February 7, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 348 Carey Avenue Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 418-76-7204 1 X M 2 F 50 03/09/1958 Permsylvania Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Maryland Salisbury 1 XYes 2 No death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 Carey Ave. 21804 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 2 X No Yes 5 72 hours after white 4 X Divorced 3 Widowed If Yes, Give Yeer Yes 2 X No specify: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Pages 1 and 2 should be filed within specialist enviromental services marked other tic event, the Me 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Walter Heyer Betty Allen Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacy Battista/sister 348 Carey Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 X Cremation 3 of F crematory or other place) Removal from State Salisbury Crematory tant: 2/10/09 Salisbury, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses ²² Hameand Address of Facility at Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, perME, g889 3/26/09 TT attending physician or use as the burial -X UNPENDED O. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be þ Records, P. 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? this certificate ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural within 24 hours after death To the Funeral Director: Director: d in by the f Yes 2X No Pending Fd 2/7/09 Fd 10:10 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City pr. Town, State) 348 Carey Ave Salisbury, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide house determined 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registra

DHMH 17 Rev 1/2001

OCME 2006

Medical

29b. Signature and title of certified

Margarita Korell MD

and manner stated

Assistant Medigal Examiner

istrar's Signature

the. 30. Name and address of person who completed cause of death (Item 23a)

1 2 2009

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 8, 2009

			1 - State Amend Item Registrar	25 State of per i	of Marylar ne,g888,	82/25/ Cer	rtment of H 09dhb <i>tificate of L</i>	lealth a D <i>eath</i>	and M	ental Hy	giene Reg. No	2009	05056
-			1. Decedent's Name (First, Middle							2. Date of De			3. Time of Death
	Physicia Medic/		MICHAEL SMITTY	JOHNSON						1/21/2		rear	1:20 a M
4	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location	of Death		4c.	County of Death	
	and the second	\$ ()	Holy Cross Hosp				Silver					lontgomer	у
	uneral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birthp	place (State or Foreign htry)
Di	rector		219-54-5376	120 W 201	57	Yrs.				3/20/1	951	Fayet	teville,NC
and	M +		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						Od. Inside City Limits
Mary	f sho	ō											1⊈Yes 2 No
the	28a- notif	Director	Maryland Montgo 10e. Street and Number	mery	S1.	lver_Sp	ring 10f. Zip Code				10g. Citi	zen of What Cour	ntry?
be filed within 72 hours after death with the Maryland tal Hydiene.	"natural", or Items 23a or 28a-f show sdical Examiner must be notified at		46 Oswego Ave.				209	10			TT 4	ed State	-
death	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	I.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba		igin? (Spe	cify Yes or No		14. Race - Americ	an Indian,
after	or Ite		1 Never Married 2 Marr	Armed F ied 1 Tes If Yes, G	2 No		r Yes, specify Cuba I□ Yes 2🌣 No			Hican, etc.)		Black, White,	
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d 2 st	7 Is r traur						g Address (Street &						
1 and Health	Important: If Item 27 Is marked any injury or other traumatic ev once.		Michael D. Johns 20a. Method of Disposition	son / Son			sition (Name of	s Ct.		Glen B		cation - City or To	and 21061
Pages nent of	1 or o		1 ☑ Burial 2 ☐ Cremation		n State	cemetery, crer	natory or other plac	· i	_			,	•
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	ansit	ē	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. SEP	r (or as a consec	querice off;		0	/	1/1/	L EXAMIN	ER	
nted		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	PNEI	JMONIA			1	NDPRO	VED BY MEDIC	dr. Eve.		
ехес	ial-tr	Exa	resulting in death) Last	0	o (or as a consec	quence of):	C	ERTIFICAT	ONE				
ate be executed	ohysician and the burial-transit	dical		d				1					
		ledi											
The law requires that the death certific	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn birth 2 ☐ Feta		Ectopic pregnancy					23d. Date of delive	ery
deal	e att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Other (specify)					Month	Day Year
at the	ed by the detached	hys	9 ☐ Unknown										
es th		by	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I		23e. Did t			ne cause of death?
equir	en si		QUADRIPLEGIA							1 🗆	Yes 2X	No 3∏ Prob	abiy 4 Unknown
law r	as be 2 sh	Completed	CHRONIC RENAL F	AILURE						24a. Was		24b. Were auto	psy findings available
The	page a	E	ANEMIA							auto perfo 1∐ Yes	ormed? 2 🔀 No	death?	mpletion of cause of
ian	iii o	Bec	25. Was case referred to medical					26. Place	of Death	(Check only		1 100	- LAITO
Attending Physician:		To E	examiner? 1 X Yes — 257 No	Hospital: 1X	Inpatient 2] ER/Outpatien	t 3□ DOA Othe	er: 4 □ Nu	ırsing Hon	ne 5□Resi	dence (5 □Other (Specif	y)
. g	fter thi		27. Manner of Death 1 ↑ Natural 5 Pending	28a. Date	e of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work	/ at	2	8d. Describe	how injur	y occurred	
endi	or: A	atic	2 Accident investig	ation			M 1 1 1	Yes 2□	No				
or Att	irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 28e. Plac build	e of injury - At heding, etc. (Special	ome, farm, stro fy)	eet, factory, office		2	8f. Location (d Number or Rura)	il Route Number,
ital c	ral D		77.										
Hospital	etoly filled in by the funeral di	ledical	(Check only 2 Medical	g Physician: To th Examiner: On the	basis of examina	owledge, death ation and/or in	occurred at the time time of the control of the con	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s)	and manner as s	tated. the cause(s)
₽ .E	₽ ₽	Med	one)	and ma	nner stated.								
P. ₹	2 00	-	29b. Signature and title of certifier	////	1 1		29c. License					e signed (Month,	
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0	7		30. Name and address of person	2-502	•	, ,							
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7	Stat		WINIFRED LEE, MI 31. Date filed (Month, Day, Year)	beneva 32.	Orest G Registrar's Siens	len Kd.	Silver	Sprin	ig, Ma	aryland	1 209	010	

State Registrar

29b. Signature and the of certifie

31. Date filed (Month, Day, Year)

30. Name



and manner stated

address of person who completed cause of death (Item 23a) (Type, Print)

the

2

29c. License number

40000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 9889 3/16/09 JH State of Maryland / Department of Health and Mental Hygiene? 05058 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 3:30 P^{M} ALBERTA C. COWANS JONES 01-24-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's CAROL'S CARE ASSISTANT LIVING Springdale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 12-30-1927 5-Social Security Number 579-34-3163 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days 1 □ M 2/5 F 81 McDowell, WV Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examinar must be notified at 1份Yes 2□No Directo Maryland | Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Eventual bear once. USA 20774 3404 Ladova Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ➡No Specify. Specify: Black ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Of Army ± 01 Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Rosa May Herrington Sylvester C. Wall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springdale, Maryland 20774 3404 Ladova Way Nolan Cowans/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 01 - 30 - 094 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 Jack Wilson Vac Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner erobrovascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to fui as a Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Jyling Chr 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.

Director: Al investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005963 30. Name and address of person into completed cause of death (Item 23a) (Type, Print)

State

Registrar

Glein

31. Day filed (Month, Day, Year)

FEB 0 2 2009

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1221 Morcantile Laure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Ye ar Month **Physician** Camille R. Jones TANUAL 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Hours Days 1□ M 2 F May 7, 54 1954 Washington DC Director 212-62-0087 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the World at Examiner must be notified at t¥ZYes 2□No Director District Heights Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20747 USA 2609 Lakehurst Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within the and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorraine E. Colbert Carl Jones, Sr. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. 7206 Dower House Road, Upper Marlboro MD 20772 (Brother) Barrington Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2009 Suitland, MD Lincoln Cemeterv 22. Name and Address of Facility of uneral Service Licer 22. Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate hy completely filled in by the funeral director, page 1 □Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭2No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar

7500 HANOVER 1). George 31. Date filed (Month, Day, Year) FEB 03 2009

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MDD58182

suite # 101A Greenbelt MB 20770

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland, Dapartment of Health condy by the Health condy by the No. 05060 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** /Medical <u>Antonio</u> 0. <u>Johnson</u> 2009 January 28, 12:10 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ™** M 2□ F 577-96-3669 47 Director Dec 21. 1961 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, The Worldon Event, inc., ust be inclined as Director Prince George's 1 Yes 2 □ No Maryland | Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 Central Avenue #204 20743 United States death \ Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after de la Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None is 1 and 2 should be filed with Health and Mental Hygier them 27 is marked other them 27 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other them 50 is marked other 50 is marked 50 is marke 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Price Sylvia Johnson ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20772$ permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 5605 South Marwood Blvd #238 Upper Marlboro, MD Sylvia A. Brown - Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Feb. 5, 2009 Clinton, MD 21. Sign ture of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Lenter the disease, or complications that caused the shock, a heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 disease or condition resulting in death) /Medical Due to ()r as a consequence of TON APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Chase (Discuss or injuly that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ło in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached fi P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 🗌 Yes 2 200 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate Vital 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only onle) examiner? 1 AYes 2 Ho 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ð this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manuar of eath 28b. Time of After t 28c. Injury at Unknown
Work? Unknown 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation Injury Natural XI Natural Coident Motor Vehicle Accident death. Unknown **Unknown**^M 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Unknown Unknown TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 3001 ATEVENIS MA 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 03 2009 Registrar

			1 - State of Maryla	-	artment of F			ene g. No. 2009	05061	
F	Physici		Decedent's Name (First, Middle, Last) Minnie Mae Johnson				2. Date of Death		3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In v.	rs. last birthday)	4b. City, Town, or Hagers If Under 1 Year		th	4c. County of Death Washington		
	Funeral Director		217-42-9365 1□ M 2⊠ F 73 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.		Year) Cou	place (State or Foreign ntry) MD	
	the Marylar 28a-f show	rector		City, Town or Lo			10	g. Citizen of What Cou	10d. Inside City Limits 1 √ Yes 2 □ No	
98	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, I'm Medical Evaninar must be notified at	/ Funeral Director	432 Summers Avenue 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Never Married 2 Married If Yes, Give		2174 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No			US 14. Race - Ameri Black, White,	can Indian,	
Baltimore, Maryland 21215-0036	within 72 hours ene. than "natural",	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired Homema.	ation during most of wo	rking 1	Specify: BIG 6b. Kind of Business/Ir Home		
land 2	I 2 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic event, Italia	To Be Co	17. Father's Name (First, Middle, Last) George V. Smith		Homema	18. Mother's Na	me (First, Middle, M 's Elizabe		n	
e, Mary	and 2 sho lealth and I m 27 Is ma her trauma		19a. Informant's Name/Relationship (Type. Print) Catherine B. Smith / Sister	321	Henry Av	enue, Ha		City or Town, State, Zip MD 21740	o Code)	
timore	permit. Pages 1 and 2 should be Department of Health and Menti Important: If Item 27 Is marked any injury or other traumatic enone.		4 □ Donation 5 □ Other (Specify)	ose Hil	sition (Name of matory or other place L Cemeter	y = 02/1	3/2009 H	oc. Location - City or To	MD	
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the di		<u>305 N. Po</u>	<u>tomac St</u>	<u>reet, Hag</u>	innich Funderstown, M	eral Home 0 21740 Approximate	
	Physician /Medical Examiner		J.,	Interval Between Onset and Death						
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Unidentifying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a constitution of the constitu							
P.O. Box 68	Attending Physician: The law requires that the death certifica redeath, ar death, ar death ar death, After this certificate has been signed by the attending play the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of pre 1 ☐ Live birth 2 ☐ F 9 ☐ Unknown	etal death 3	Ectopic pregnancy	/		23d. Date of delive	ery Day Year	
rds, P	w requires that s been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death but not ANGIOEDEMA	resulting in the u	nderlying cause give	en in Part I.		acco use contribute to t	he cause of death?	
tal Reco	in: The law re ificate has be or, page 2 sho	Completed by	25. Was case referred to medical					prior to co death? ☑No 1 ☐ Yes	psy findings available impletion of cause of	
of Vi	Physicia this cer al direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2			er: 4 🗆 Nursing F		nce 6 ☐ Other (Specia	(y)	
	5.9 = 6	Certification:	27. Manney of Death Matural Sean Date of Injury (Month, Day, Year) Accident Suicide Gould not be determined Could not be building, etc. (Special County)	t home, farm, str	M 1 🗆	y at ?? Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Rura	al Route Number,	
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner as ste and place, and due to	stated. o the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier , H. Cluttary M.D.		29c. License			d. Date signed (Month,		
SH	1-4		30. Name and address of person who completed cause of death (I	tem 23a) (Type,		3853 HAG				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 9 2009 32. Registrar's Signature	gnature.	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State 2-5-09 State 2-5-09 Registrar Amend#'s1.4b.PerPhys.20b.PerFHPCCcrCertificate of Death 05062 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dora Funari Kennedy Dora Furani Kennedy 2009 12:49 PM Feb. 1, /Medical Takoma Tacoma Park la. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 □ M 2 🛛 F Months 87 287-18-5471 Director 1921 Bellaire, Ohio March 8, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the thedical Eventrant nust be notified at Director 1⊠Yes 2 No Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4806 Harvard Road 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No or items, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: ģ Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Prince George's College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educator Board of Education is 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other them 27 is marked other them 15 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pietro Matozza Giuseppina Marinelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Dallas C. Kennedy, II / 48 Village Brook Lane, Natick, MA 01760 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -1/9/2009 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. Adelphi, Maryland 21. Signature of Furleyal Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEMI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEFICILLIS COLLYTI Physician/Medical Exami LOSTRIDIUM g physician and is the burial-trans Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t autopsy performed's certificate 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yee 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

law requires that the death certificate be executed 68760, P.O. Records, Division of Vital

Maryland 21215-0036

Baltimore,

PAHI

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Physician: The After or Attending thours after death. uneral Director: Aftely filled in by the fur thin 24 hours at the Funeral D Hospital To th. within 2.

2 Accident

4 ☐ Homicide

3 Suicide

29a, Certifier

29b.

Medical

State

(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
Signature and title of certifier Attend, Phy	7. 019897	29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 2, /, 09

6 ☐Could not be determined

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CREENSELT MD2°77= ANOVER 209 31. Date filed (Month, Day,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar 05063 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Jan. 29, 2009 **Physician** Kaplan Sidney 10:00M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse at Westwood Montgomery Bethesda 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5 / 04 / 1912 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. NY, NY 1**X** M 2□ F 96 090-24-3172 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at MD Montgomery Bethesda 1 ☐ Yes 2 🕍 No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any Injury or other traumating. the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5101 Ridgefield Road 20816 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Postal Service Federal Gov't 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Kaplan Hanna Cahan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Fred Kaplan/Son 5603 Ridgefield Road Bethesda, Md 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Chesapeake Crem. 1/30/2009 Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature P部門門 AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cellulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-transit Renal failure Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 TVes 2 TNo detached 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Prysium...
within 24 hours after death.
To the Funeral Director; After this certificate has ' autopsy perform death? 1 ☐ Yes 2**⊠** No 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be assisted Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Tes 2X No ျ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number D35579 Jan. 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Miller MD 8218 Wisconsin Ave. #305 Bethesda, Md 20814 31. Date filed (Month, Day, Year) . Registrar's Signature State FEB 04 2009 Registrar

			1 - State of Maryland /	Department of Health and Me Certificate of Death	ental Hygiene 200	9 05064					
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Richard Ken+		2. Date of Death Month Day Yea CONTROL OF THE PROPERTY STATE OF T	3. Time of Death 2:58 A M					
	Examin	er	4a. Facility Name (If not institution, give street and number) University of Mayland Medical Cer	nter Baltimore	4c. County of De						
	Funeral Director		5. Social Security Number 093-38-1195 Usual Residence of Decedent	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. E	Sirthplace (State or Foreign Country) MD					
	aryland show	or	10a. State 10b. County 10c. City, To	wn or Location STERTOWN		10d. Inside City Limits X☐ Yes 2☐ No					
	ith the M or 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What						
	death w ms 23a	Funeral	208 GREENWOOD AVE 11. Marital Status 12. Was Decedent Ever in U.S.	21620 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	USA Sify Yes or No- 14. Race - Ar	merican Indian,					
9800	ours after ral", or ite Examina	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Ye ar or Dates:	1 □Yes 2 ĀNo Specify:	0	white, etc.					
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantiner must be notified at or other traumatic event, the Medical Evantiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NAVAL ENGINEER	g 16b. Kind of Busines ENGINEERI	·					
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Maryland	2 should be n and Mental is marked or raumatic ev	7	MYRON HOWELL KENT 19a. Informant's Name/Relationship (Type. Print) 1	9b. Mailing Address (Street and Number or Rural		2 Zin Code)					
	1 and 2 s Health ar tem 27 is		JOSEPH FLANAGAN/EXECUTOR	207 S. CROSS ST. SUITE	101 CHESTERTOWN	, MD 21620					
Baltimore,	Pa int		Digital 2 Li Cremation 3 Li Removal from State	of Disposition (Name of tery, crematory or other place) AWN CEMETERY 2/18							
Ball	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee	N & NEWNAM FUNER TERTOWN, MD 2162	AL HOME						
0	Physician /Medical		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
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Division of	i or Attending Ph after death. Director: After thi I in by the funeral i	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home.	M 1 ☐ Yes 2 ☐ No farm, street, factory, office 28	8f. Location (Street and Number or	Rural Route Number.					
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner d at the time, date and place, and d	as stated. lue to the cause(s)					
	with com	Σ	29b. Signature and title of certifier MD	29c. License number 1457481947	29d. Date signed (Mo						
_	0.		30. Name and address of person who completed cause of death (Item 23.) ASN WY WEVMINK MD 22	C Greens Ctreet Ba	eltimore, MD	2120)					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB - 9 2009	A. Sales							

Amend Items 25,27,28a-f per me, g889,03/06/09dhb

Ear AMFN #1 Per Phy State of Maryland / Department of Health and Mental Hygiene For AMEND#1 Per Phy. Reg. No. 20 State Registrar 1/30/09 AACO HEALTH DEPT. CMH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Theodore S. Kuchta Jr Month Year **Physician** CUCKMA TAL 23011 25 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Stic Little MAgothy ViewRo 4 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age ((In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□F 220-60-8008 Maryland Director Jan. 07,1951 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10h. County 10d Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 1122 Little Magothy View 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Architect Architecture other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Theodore S. Kuchta, Sr. Ann Mary Andresky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Tuero Kuchta/ wife 1122 Little Magothy View f Health Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any Injury or o once. 31, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. 2009 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Trteriosclerati /Medical Due to (or as a consequence of) Examiner Y pothermia
V(orlas a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown ned by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signer should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 No Physician; 25. Was case referred to medical examiner?
1 → Yes 2 → No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this s after death.

Il Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Found 1 Day Year) 01/25/2009 Found: 10:50 p. or Attending Natural 5 Pending investigation 1 Natural 2 Accident Subject exposed to cold 1 🗌 Yes 2 📉 No environment. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Bural Route Number, City or Town, State) 1122 Little determined 4 ☐ Homicide Home Magothy View Rd., Cape StClaire, Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a Certifier Medical within 2 and manner stated eputy 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES mD Registrar

		Amend #5 p	er FH G889 : se Type or Prin								-		
		For State Registrar	State of Ma	aryland		artment of F ctificate of I		and M	lental Hy	giene Reg. No	2 n n o	050	68
Physicia /Medic		1. Decedent's Name (First, Middle Mildred Kent							2. Date of De Month Janua	ry	25 2009		
Examin	er	4a. Facility Name (If not institution, Anne Arunde1 5. Social Security Number	Medical C	ente	r ast birthday)	4b. City, Town, or Annap If Under 1 Year	olis		8 Date of Bir		County of Death		Foreign
Funeral Director		220-32-351616 Usual Residence of Decedent	1□ M 2∏ F	8	8 Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, De Feb 5	19	20 Mar	yland	
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th with th		10e. Street and Number 5 Arbor Hill	Rd.			10f. Zip Code 214	03			-	tizen of What Cou USA	ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine must be neithed once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:		1	Vas Decedent of H fYes, specify Cuba I□Yes 2XNo	ispanic Ori an, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Amer Black, White Specify: B1a	etc.	
thin 72 hou le. an "natura	Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	5+)	(Give	dent's Usual Occup kind of work done o OO NOT use retired	durina mosi	t of worki	ing	16b. K	ind of Business/li		
be filed wintal Hygien od other the event, the		8th 17. Father's Name (First, Middle, L	Last)		Hea1	th Care	18. Mothe	er's Name	e (First, Middle	, Maiden	rsing F Surname)	ome	
id 2 should tth and Mei 27 is marke traumatic	10	Mack Carroll 19a. Informant's Name/Relationsh Mary Brewer(I				g Address (Street	and Numbe	er or Run		er, City			
Pages 1 ar nent of Hea nt: If item:		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State	20b. Pr	De of Dispo	eitign (Name of hator) or other plac 1 Park	e)		Date	20c. Le	, Md. 2 ocation - City or T napolis	own, State	
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Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									ath		
ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as c Due to (or as d										
To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnanc	у				23d. Date of deli Month	very Day Yea	ar
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Physicia this certiral director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatier		er: 4□ Nu	ırsing Ho		idence	6 ☐ Other (Spec	ify)	
or Attending after death. Director: After in by the fune	Certification: To	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation (Month, Da	ay, Year)	Injury	Worl	yal k? Yes 2∐I	No	28d. Describe 28f. Location (City or To	Street ar	nd Number or Ru	al Route Numbe	ır,
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To the To the comp	Me	29b. Signature and title of certifier	Su			29c. Licens		1 3		29d. Da	ite signed (Month	Day, Year) - 200	
100			who completed cause of d	death (Item	23a) (Type,	Print)			e 842	2	Boure		
Sta Registra	ar	JAN 3 0 2	2009 Section	rars Signati	ure Laca	reville							
HMH 17 Rev 1/20	001				-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05067 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death KNIGHT Month **Physician** 2021 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Tate Hospice House Anne Arundel Linthicum 8. Date of Birth (Month, Day, May 19 9. Birthplace (State or Foreign N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral ^{Year)}930 Hours Months Days 1 M 2 □ F 241-32-2932 N. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 137 Foxwell Bend Rd. 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Folds: 1 Byes 2 No If yes, Give Year or Dates: Korean 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2**X**☐ No Specify. þ 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Press Operator Department of State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Little Mary Coppedge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Ann Knight(Wife) Foxwell Bend Rd. Glen Burnie, Md. 137 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1-30-09 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Md. AmName Reverse of & cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Betwo Onset and D Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and Due to (or as a consequence of): burial P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 □No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ 2 No icate has been si page 2 should b 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Pottler (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred House 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide thin 24 hours a 29a. Certifier Medical npletely (Check only and manner stated. 29b. Signature and title of certified 29c. License number

Registrar

30. Name and address of person whi

completed cause of death (Item 23a) (Type, Print)

A FNOW MYT DEFENSET GHWAY ANNAPOUS MAZIYU, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend sittem of Maryland / Separtine of Health and Mental Hygiene 2009 05068

			1 - State Registrar	Otato of Ivra		ertificate of I			eg. No.	9 05068
	Physici	an	Decedent's Name (First, Middle, Las MARY	FRANCE	Т	OVELACE		2. Date of Dear Month JANUARY	th Day 2009	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give		<u></u>		r Location of Death		26 2009 4c. County of De	11:00 A M
	LAGIIII		WASHINGTON ADVE	NTIST HOSP	[TAL	TAKOMA			MONTGOM	ERY
	Funeral Director		5. Social Security Number 239-96-6293 Usual Residence of Decedent	ex 7. Age 7. Age 7. Age 7. Age 7.	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 15	Year) 9. Bi	rthplace (State or Foreign Country) RTH CAROLINA
	aryland show		10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
	e Mar 3a-fsh	Funeral Director	MD PRINCE GI	EORGE'S	UPPER	MARLBORO				1 Yes 2 No
	with the	Dir	10e. Street and Number 15110 PEERLESS A	VENUE		10f. Zip Code 2072		1	0g. Citizen of What C	Country?
	ns 23	neral	11. Marital Status	12. Was Decedent E	ver in U.S. 13			pecify Yes or No-	USA 14. Race - Am	nerican Indian
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, it o Modical Examination must be notified at	by	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 □Yes 2X No If Yes, Give Year or Dates:	0	l. Was Decedent of H If Yes, specify Cuba 1 □Yes 21□No	an, Mexican, Puerto Specify:	o Rican, etc.)	Black, Whi	ite, etc.
15-0	"natu	letec	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	16a. Dec (<i>Gi</i>)	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of work	king	16b. Kind of Busines:	s/Industry
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pu	e filed al Hygi other vent, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I		
ylaı	should be f and Mental I s marked oi umatic eve	T0	ALBERT GRAHAM				ETHEL L	EGGETT		
Maryland	12 s hai 7 is trau		19a. Informant's Name/Relationship						, City or Town, State,	
	s 1 and 2 if Health item 27 i		JAMES GRAHAM/SON 20a. Method of Disposition		20b. Place of Dis	position (Name of			MARYLAND 2 20c. Locatino Rite	
ë.	Pages nent of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ematory`or other plac IH HGTS. C			UMBERTON,	OMOBINA
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any-tnjury or other once.		21. Signature of Funeral Service Licen	See		22. Name and Addres	ss of Facility J	. B. JEN	KINS FUNER	AL HOME
	20 = 00		23a. Part 1. Enter the disease, or comp	lications that caused t					R, MARYLAND	20785 Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Al	DIDPUL	MORARY	ARRE	S or respiratory arr	est,	Interval Between Onset and Death
	Examiner			Due to (or as a	consequence of):	SHOCK				
	D ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):	00	0.0	0 0 -		
	ecute and trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Duata (ar as a	CONSEQUENCE OF):	16 KET	tal Di	SEASE		
68760,	rificate be executed ig physician and as the burial-transit			Due to (or as a	consequence or).					
68 7	tificate ng phy as the	Medical		d						
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒ No 9 □Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death	Ectopic pregnance	у		23d. Date of de Month	elivery Day Year
σ.	that the led by detac		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
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ဝ၁	law requir as been s 2 should	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
<u> </u>	: The law cate has page 2 s	Com						autops perform 1 □Yes 2	ned? death?	s 2 No
Vita	Physician: T r this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		ont all post Other	or:	th (Check only on		
of	y Phys er this eral dii	<u>ان</u>	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury	t 2 ER/Outpat y 28b. Time	of 28c, Injur	4 ⊔ Nursing H		ence 6 Other (Sp	ecify)
ion	Attending for death. ector: After by the funer.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	Work	ί? Yes 2 □No		, ,	
Division	tal or Atters as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Ph	ysician: To the best of niner: On the basis of and manner stat	examination and/or	ath occurred at the tir investigation, in my o	me, date and place pinion, death occu	e, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	Veith Com	Σ	29b. Signature and title of certifier	MA		29c. Licens	e number	2	9d. Date signed (Mon	ith, Day, Year)
	<i>a</i>		The contracts	IVID	-N- //		277	e.o	MILLARY	2+ 2009
12	-1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type 132511	ANDIA	PAZKNI	ty GRCA	FriRCIT M	27 2009 HRYLHW020770
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	111000	1110	· J VINE	- 13ey 11	IN TO HO

DHMH 17 Rev 1/2001

State

Registrar

FEB 0 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Februar) 5.53 PM Ricky Eugene Leal 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Prince George's Doctors Community Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Min. Months Days Hours 1⊠M 2□F 152-30-3458 June 2, 77 1931 Cabaiguan, Cuba Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1XYes 2 No Maryland | Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 USA 7821 Mandan Road, #103 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ⊠Yes 2 No
If Yes, Give
Year or Dates: 1956–1959 1 ☐ Never Married 2 X Married 1⊠Yes 2□No Specify: Cuban Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Waiter Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diego Leal Torres Concepcion Respaldiza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Leal / Wife 7821 Mandan Road, #103, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2/5/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAU LOGANS de Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Z. deys. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hronic Obstruct 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

至

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Modell Exercited any injury or other traumatic event, It's Modell Exercited.

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Baltimore, Maryland 21215-0036

burial-transit and attending physician for use as the buria filled in by the funeral director, Hospital or Attending P
 24 hours after death.
 Funeral Director: After t After

Physician/Medical

Completed

Certification: To

Medical

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown 25. Was case referred to medical

1∐ Yes	2 1No	
27. Manner of		
1- Natur	al 5[
2 Accid	lent	
3 Suicio	de 6[

4 Homicide

29a, Certifier

Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 31001 29d. Date signed (Month, Day, Year) 2/3/2009

Name and address of person who coopleted cause of death (Item 23a) (Type, Print) 7500 Green wov Cntr. Dr. #430 7 MD. Kerrit Ur

State Registrar

Date filed (Month, Day, Year) FEB 0 5.2009

32. Registrar's Signature

70

To the Hospital of within 24 hours a To the Funeral D

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05070 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Toy 30, 2009 н. Lee January 4:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bedford Court Skilled Nursing Center Silver Spring Montgomery 8. Date of Birth (Month, Day Year) Aug. 30. 1914 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 😿 F Months Days Hours China 577-70-3177 94 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location iral", or items 23a or 28a-f shov Examinar must be notified at Director tx Yes 2 □ No <u>Washington</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 2812 28th Street, 20008 USA NW Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asi<u>an</u> If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 9 Specify. 3√ Widowed 4 □ Divorced "natural" Completed er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.

27 is marked other than traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gung Lim Pua Lee ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Lena F. L. Auerbach/Daughter 2812 28th Street, NW, Washington, DC 20008 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 20d9 Feb. permit. Pages
Department o
Important: If
any Injury or = 5 1 → Burial 2 Cremation 3 Removal from State 4☐Donation 5 ☐Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Silver Spring, 500 University Blvd., W., MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Torminal Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. First Indentity Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2XXXIo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Hypertension, Failure To Thrive, Bronchial Asthma 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the rector, page 2 standard autopsy 1 □ Yes 1 ☐ Yes 2 No 2 No After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Q Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Assisted 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Living 5 Pending investigation 1 Natural ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature a dititle of vertifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 February 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rajan Shyamsundar, MD 9801 Georgia Avenue, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2230 M THEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Linthicum

Hader 1 Year I If Under 24 Hrs. Tate Hospice House Anne Arunde1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 Z F 69 Director 219-26-5515 29 1939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, its "hocked Example mant to notified at 1 ☐ Yes 2 😾 No Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 575 Welland Ct. 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Crofton Convalescent Elementary/Secondary (0-12) 12th College (1-4or 5+) Nursing Assistant Rehab Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unobtainable ဥ Martha Conway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 Welland Ct. Deborah Armstead(Daughter) Millersville, Md. 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Rest Cemetery 1-29-09 Honover, Md. Wante Reduces of SacilSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 resemucy83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of): law requires that the death certificate be executed use as the burial-trans and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 No 9 Unknown 9 Unknow vare nas been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 / No 1 🔲 Yes 3 Probably 4 Unknown Completed -24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dine 1 Yes 2 No RICLE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred HOUSE 5 ☐ Pending investigation 1 Natural

□ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 ∏No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only Signature and title of certifie 29c. License number W

State Registrar Name and address of pe

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

who con pleted cause of death (Item 23a) (Type, Print

W

egistrar's Signature

NA

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0 2009

Year)

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			For AMEND#4C Per 1 State Registrar AACO HEAL	TH DEPT. 2/3/		•	rtificate of		na mentai m	ygier Reg. 1	2009	05072	
	Physic	an	Decedent's Name (First, Mid	1		· <u> </u>			2. Date of D Month		Day Year	3. Time of Death	
4	/Medi Exami	cal	4a. Facility Name (If not instituti	ion, give street and num	ber)		4b. City, Town, o	r Location of	Death		4c. County of Dea	th Prince George	
7	Examil	ier	2508 Kitmore	-			Bowi				20715		
	Funeral Director		5. Social Security Number 232–38–7946 Usual Residence of Decedent	6. Sex 7 1 ☐ M 2X☐ F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, D Mar. 3	∂ay, Yea	ar) Co	thplace (State or Foreign ountry) Virginia	
	land ow		10a. State 10b. Count	ty	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	a-f sh	cto	MD Princ	ce George's	Bow	ie						1 □Yes 2 XNo	
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?	
	s 23a	eral	2508 Kitmore				20715		0.00		US		
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Mcdical Evarring or ust be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	If Yes, Give	ces? 2 X No 8		Vas Decedent of F f Yes, specify Cub □ Yes 2☑ No		n? (Specify Ye's or N Puerto Rican, etc.)	10-	14. Race - Ame Black, Whit		
5-(72 h	ete	15. Decede (Specify only high	ent's Education nest grade completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	oation during most o	f working	16b.	Kind of Business	/Industry	
12	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12)) College (1-	4or 5+) 2		ical	a)			optical		
	il Hygi other	BeC	17. Father's Name (First, Middle					18. Mother's	s Name (First, Middle				
<u>/lar</u>	should be fand Mental I s marked of umatic ever	To E	John Lev	vis				M	ary unkno	wn			
Maryland			19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	g Address (Street	and Number	or Rural Route Num	ber, Cit	y or Town, State,	Zip Code)	
	s 1 and 2 of Health Item 27 i		Fred J. Lopez 20a. Method of Disposition	/ spouse	20h F		Kitmore,		Bowie,	_	20715 Location - City or	Town State	
р	00 0 -)	1 ☐ Burial 2 🎛 Cremation		tate		sition (Name of natory or other place			1	-		
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other of 21. Signature of Funeral Service		Bay		rematory Name and Addre		/29/2009 Boall		ltimore, eral Home		
ä	Per Per Per Per Per Per Per Per Per Per		DK.P.	27		1	512 NW C	rain H			MD 20715		
	Physician		23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complications that ca st only the cluse on ea a.	used the deatl ch line.	h. Do not ent						Approximate Interval Between Onset and Death	
τ'	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):						·	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a conseq	uence of):							
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.									
68760,	icate be executed physician and the burial-transit	resulting in death) Last Due to (or as a consequence of): d.											
39 x	ertifica Jing pl	Med	IF FEMALE:										
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the buriat-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of c	Ideath 3	Ectopic pregnand Other (specify) _	у			23d. Date of de Month	livery Day Year	
Records, F	w requires that been signed I should be det	ρ	Part II. Other significant condi	tions contributing to dea	ath but not res	ulting in the ur	nderlying cause giv	en in Part I.				o the cause of death?	
al Rec	Ician: The law r certificate has be ector, page 2 sh	Completed							24a. Wa auto peri 1 □ Yes	opsy formed	prior to death?	utopsy findings available completion of cause of	
Vital	sician; certific irector,	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:			+ 3 □ DOA Oth		f Death (Check only				
	ding Phys h. After this funeral dii	n: 10	27. Manner of Death	28a. Date o	f Injury	28b. Time of	28c. Inju	ry at	ing Home 5 1 Res			ecify)	
ioi	Attending it death. ector: After by the funer	atio	2 - 7100100111	stigation	n, Day, Year)	Injury	M 1 □	k? Yes 2∐No					
=	i i i i i	Certification:	3 ☐ Suicide 6 ☐ Coulle determined	rmined 286. Place C	of Injury - At ho g, etc. (Specif	ome, farm, stro	eet, factory, office		28f. Location City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in I	Medical	29a. Certifier Check only Cone) Certify Medica	ying Physician: To the ba al Examiner: On the ba and manne	sis of examina	wledge, death	occurred at the tivestigation, in my	me, date and opinion, death	place, and due to the occurred at the time	e cause e, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)	
	Vith Con E	Σ	29b. Signature and title of certif	ier			29c. Licens	se number		29d. I	Date signed (Mont	th, Day, Year)	
				7			D6	52 +0	2	1	128/19		
0	#3		30. Name and addless of person	KILV GUD	gistrar's Signa	n 23a) (Type	Print) Su.	H 3	00 Dm	6.71	s Mo	21411	
	Sta Regist			2 2009	wa	B. 6	arles						

DHMH 17 Rev 1/2001

			For State Registrar		Sta	ate of	Marylan	d / Dep <i>Ce</i>	artmer	nt of F <i>te of l</i>	lealth Death	and N	1ental Hy	gien Reg. No	^e 200	9	0507	3
	Physicia	an	1. Decedent's Nam		,	TOT	ELE		T	ANE			2. Date of De Month		ay Y	ear	3. Time of Death	1
	/Medic		4a. Facility Name (ICHAR							r Location	of Death	Feb.	40	20. County of	= -/	7:45 P	_
13	Examin	lei		North	-					Jar	rett	svi	lle		Ha	rfo	rd	
	Funeral		5. Social Security I		6. Sex 1 X M 2	7 0 F	. Age (In yrs.	-) If Unde Months	er 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	av. Year	r)	Coun		n
).	Director		216-34- Usual Residence of		1,25,141 2		70) Yrs.					12/3/	193	8	Ma	aryland_	
	ow other		10a. State	10b. County			10c. City	y, Town or L	ocation							1	0d. Inside City Limits	;
	Mary n-f sh fled a	to	MD.	H	arfor	d			Ja	rret	tsvi	ille					1 □Yes 2 X No)
	or 28g)irec	10e. Street and Nu						10f. Z	ip Code				10g. C	itizen of Wha	at Cour	itry?	
	23a ust b	ral	2360	North							1084				nited			
36	n /2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notifiled at	by Funeral Director	 Marital Status Never Mar Widowed 		ried Ar	med Fore ☐ Yes Yes, Give	2 X No	S. 13.	. Was Dece If Yes, sp 1 ☐ Yes	ecify Cub	lispanic O an, Mexica <i>Specif</i> y	an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.	
5-0036	hours tural'	q pa	3 🗀 Widowed		t's Education	earorDa	ies.	16a. Dec	edent's Us	ual Occur	ation			16b. I	Kind of Busir		hite	
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nor C	Pages net of int; If it		1 Burial 2	Cremation 5 ☐ Other (5		al from S	itate	emetery, cr	•		i i	^ /1 Z	/2000	TO - 1	37		M 7	3
ich art. Baltimore,	ortan		21. Signature of F			(17	TRUNTE	w Me	22. Name a	and Addre	ss of Faci		G Ku	rta.	LISTO	n,	Maryland Tuneral	1_
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	Te 18		23a. Part1. Enter shock, or he	the disease, o	r complication	ns that ca	usor the deat	h. Do not e									Approximate Interval Between	
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	/Medical Examiner		resulting in death)		-	or as a conseq							-				
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	nted I Insit	Examiner	Sequentially list c cause. Enter Und Cause (Disease of that initiated even	lerlying - or injury	<													
o,	ate be executed ohysician and the burial-transit		resulting in death)		c	Due to (or as a conseq	uence of):										
8760,	cate be exphysician the buria	dical			d													
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30)	leath certific attending p	Physician/Me	23b. Was decede		1	□Live bi	ome pf pregna rth 2□Feta	al death 3	□Ectopic		у				23d. Date of Month		ery Day Year	
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σ.	that the de led by the a detached i	, Ph	Part II. Other sign	nificant conditi	ons contribut	ing to de	ath but not res	ulting in the	underlying	cause giv	en in Parl	i.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?	
rds	w requires to been signer should be	Completed by											1	Yes :	2 ∑x No 3	☐ Prob	ably 4 Unknown	n
Ö	s beel	lete											24a. Wa		24b. We	re auto	psy findings available	e
Re	sician: The law certificate has b lirector, page 2 s	шо											auto per 1 Yes	opsy formed? 2 23 N	dea	ath?	mpletion of cause of 2□ No	
ital	lan: rtifica ctor, p	Be C	25. Was case reference	erred to medica	ıl						26. Pla	ce of Dea	th (Check only					
> -	hysic his ce I direc	10	1 ☐ Yes 20		Hospit	al: 1 □ lr	npatient 2	ER/Outpati	ent 3 🗆 E	DOA		lursing H	ome 5 Res	sidence	6 □Other	(Specif	y)	
0 4	Ing Pi	:uo	27. Manner of Dea 1 X Natural	5 Pendi	ng	a. Date o (Monti	of Injury h, Day Year)	28b. Time Injury	·	28c. Inju Wo			28d. Describe	how inj	ury occurred			
sio	ttendl feath. for: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	invest 6 ☐ Could	not be	o Place	of injuny - At h	omo farm s	M front foots		Yes 2	_No	20f Location	(Stroot	and Number	or Pur	al Route Number,	
Division or Vital Records, P.O. Box	or Al after d Direct in by	Certification:	4 ☐ Homicide	deterr	nined 20	buildir	of injury - At he ng, etc. (Special	fy)	sireet, racti	ory, office			City or To	own, Sta	ite)	or mura	a noute ivarriber,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Sal	29a. Certifier (Check only										, and due to th					
	the Hi in 24 the Fi	Medical	one)		а	ind mann	er stated.	allori arid/or					rred at the till					
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			1	malh	njem	nu	CMI)		- 1	04.3	44	14	ચ	112/	20	909	
			30. Name and ad	dress of persor	who complet	ted cause	of death (Iter	n 23a) (Type	e, Print)	12 0	11712	140	Lu-	111-7) (/://	1:-	m12 -210	92
- Le	Sta	ate	31. Date filed (Mac	poth Day, Oal	1000	2. R	egistrar's Sign	ture /	12014	., 30		, - 0	(/		20/00		m12 210	_
	Regist			FR To	anna /	Alex.	in fi	· 1400	A Comment									

DHMH 17 Rev 1/2001

Dr

/Medical P.O. Box 68760 of Vital Records. Division

Examiner Examiner inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Completed by Physician/Medical signed by the ed To Be After thi efter death.
I Director: Aft
d in by the fur within 24 hours e To the Funerel C completely filled To the Hospital

Physician

/Medical

10a State

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Completed by Funeral

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id 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygiene. 27 I marked other than "natural", or Itama 23s or 28e-1 show "traumatic avant, If a Macilcal Examinatic must be notified at

Pages 1 and 2 should by train of Heelth and Menta tant; if itam 27 is marked jury or other traumatic and the streamstic and the

permit. Pages 1
Department of H
Importent; if its
any injury or ot

Physician

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 2 Accident 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Home LIPSCOMB RD; AURONAWY 26705 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Certification:

Registrar

DHMH 17 Rev 1/2001

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ISER MO

ween M)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Racex

Month, Day, Year)

margaret

31. Date filed

888 Ulmona

D26650

09-00858 Carl Mclean Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

l Mclean	1	1- For State of Maryland / Department of Fleath and Morkey 1990	Reg. No.				
Physicia		Registrar 2. Decedent's Name (First, Middle,Last)	Date of Death Month Day	3. Time of Death Year 0750 hrs			
diçal Exami	ner	Carl McLean Ja	anuary 29, 20	c. County of Death			
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center 4b. City, Town, or Location of Death Cheverly		Prince George's			
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8.	, Date of Birth (MM	WDD/YYYY) 9. Birthplace (State or Foreign North			
Funeral Director		238-50-5694 1XM 2F 75 Yrs. Wolfills Days No. 1	01/16/19				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 X Yes 2 No			
nd show	_	MD Prince Georges District Heights	10g Ci	10g. Citizen of What Country?			
Maryla 28a-f d at on	Director	10e. Street and Number 10f. Zip Code	109. 01				
h the l 23a or 10tifie		519 Drum Avenue 20743 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific	fy Yes or No-	Yes or No- 14. Race - American Indian, Black,			
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	White, etc.			
iter des	/ Fu	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Lio	Specify: Black b. Kind of Business/Industry			
ours a atura xamin	d by	16a, Decedent's Usual Occupation (Give kind or work		, NING OF BUSINESS/INCLUSION			
36 n 72 h nan "n iical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+) Laborer		Private			
21215-0036 Juld be filed within 72 hours after Menell Hygieral marked other than "natural", or event, the Medic-I Examinez.	Completed	11 Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (Fi	irst, Middle, Maide	en Surname)			
215 215 be filed atal Hy rked o	Be C	James Edward McLean Malve	nier W	actor City or Town State Zip Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers. Importants. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trannantic event, the Medical Examiner must be notified at once.	ြင	19a. Informatics Nation Control (1996) 1 and 1					
MD and 2 sho ealth and em 27 is reaumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20	c. Location - City or Town, State			
Ore ges 1 a t of He : If it		1 X Burial 2 Cremation 3 Removal from State	14 /2009 B	Brentwood, MD			
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft.	Lincoln	runeral nome, inc.			
Department Department of the principal control		Jour Montgomers Cheatian 3401 Bladensburg Rd	Brent	shock or heart Approximate Interval			
Physician		23a. Pall I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	oop.ia.ci.y	Between Onset and Death			
*Medica mine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					
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50, tte be executed hysician and	Sal						
30, te be e ysician	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery			
68760, certificate be anding physicises the buriling season the bu	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy	Month Day Year			
Box 68760, c death certificate be the attending physic and for use as the bund.	Physician/	past 12 monato. 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown					
that the de	Ph		23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
ires that the signed by	1 E	Chronic alcohol abuse; Hypertension	24a. Was an	24b. Were autopsy findings available			
cords, aw requir has been s	Completed by		autopsy performe	ed? death?			
Recc The lay		26 Place of Death (Check o	1 Yes 2	No 1 Yes 2 No			
tal Rec	B B	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other'4 Nursing		esidence 6 Other:			
of Vi		1 V Yes 2 No 28b. Time of Injury 28c. Injury at Work?	28d. Describe how	w injury occurred			
on C ending ath.		1 V Natural 5 Pending 1 Yes 2 No	(0)	eet and Number or Rural Route Number, City			
Division of Vital Records, talor Attending Physician: The law requir rs after death.	in by	Suicide 6 Could not be	or Town, Stat	te)			
Spital hours a	ballied		due to the cause((s) and manner as stated.			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attention of the funeral Director of the first process 2 should be described for an account of the control of the described for an account of the control of the described for an account of the control of the described for an account of the control of the described for an account of the control of the contr	ippletel	29a. Certifying Physician: To the best of my knowledge, death occurred at the tirrle, date and place, and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number	it the time, cate an	la piace, and day to the out of			
To To	noo	29b. Signature and title of certifier 29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)			
		Pet a - foller -s O.C.M.E.		January 30, 2009			
1 4		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201				
1-1		Patticia Aromica-i Gran Vest					
	Sta	te 31. Date filed (Month, Day, Year) 32. Registrats Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** KINES McDONALD 09 16:46 AM JAMES 01 -24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL Montgomery Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12-02-1940 Months Days Hours Min. Washington, DC 1 [3-M 2 □ F 68 Director 577-56-0638 Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evanging a ust by notified at Director 1 ☐ Yes 2 ☐ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20018 3111 South Dakota Avenue, N.E. Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Medical Evant ner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No δ Specify. Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Maintenance 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleo Kenner ౖ Henry McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin McDonald/brother 3111 South Dakota Ave. NE Wash., DC 20018 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery | 02-04-2009 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 MO1521 Shawn C. Avlesworth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 2 **N**0 1 ☐Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 KER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Iniury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

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The law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records,

with the Maryland

death

should be filed within 72 hours after

altimore, Maryland 21215-0036

this funeral I Director: within 24 hours aft To the Funeral D completely filled in

Certification:

Attending Physician: Hospital or

State

27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pendina investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide XXXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 LITTLE PETUXENT PKWY. COLUMBIA, MARYLAND 21042 DELEON M.D.

31. Date filed (Month, Day, Year) FEB 0 5 2009

32. Registrar's Sign

Registrar

6/20

FEBRUARY 1, 2009

09-01053 Antonio Drexel Mathis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 05078

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	Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	N	Date of Death Month Day	/ Year	3. Time of Death
Vle	dical Exami		An tonio Drexel Mathis 4a Facility Name (if not institution give street and number) 4b. City, Town, or L		ebruary 4, 2	4c. County of Deat	
			4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center 4b. City, Town, or L Cheverly		7.4	Prince Georg	e's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		. Date of Birth (M	M/DD/YYYY) 9. Bi	rthplace (State or Foreign puntry)
	Director		578686793 1XM 2 F 56 Yrs. Months Days	s Hours Min.	11 15	1952	D.C.
	,	L	Usual Residence of Decedent				10d. Inside City Limits
)	w any		10a. State 10b. County 10c. City, Town or Location	1			1 XYes 2 No
٤	faryland 28a-f sho at once.	흱	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Cou	intry?
5	ne Mar or 28 fied a	Director	1223 Quaker Ln # 103 223	14		USF	7
	with the se 23a	曺	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hist 14. Was Decedent of Hist 15. Was Decedent of Hist 16. Yes specify Cuban	spanic Origin? (Specif	fy Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
	death or iten	Funeral	1 Never Married 2 Married 1 Yes 2 X No			Specify: B	lank
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	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medical Examiner must be notified at once	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				te, Zip Code)
	fore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the M nt of Health and hental Hygiene. t: If iten 27 is marked other than "natural", or itens 23a or 2 other traumatic event, the Medical Examiner must be notified		Quan Mathip-Dayonter 1016 Dood	Branch C	t. Uppe	r Warl b	010, MD20774
	ore, ME es 1 and 2 s of Health ar friem 27		crematory or other place)				
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	Baltimore, permit. Pages 1 a Department of He Important: If its injury or other tr						
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		ia la	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	- X			
		Examiner	cause. Enter Underlying Cause (Disease or injury inderthicales) Due to (or as a consequence of):				
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	i, P.O. ires that the signed by	by P		given in rait i.			robably 4 🗸 Unknown
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	cords law requi	1 =			autopsy perform 11 ✓ Yes 2	ed? death	?
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	n of Vit Jing Physia After this funeral dir	=	286 Date of Injury 28h Time of Injury 28c Injury		28d. Describe ho unk	w injury occurred	
	Sion Vitendi death. sctor:	ication:	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office		28f Location (Str	eet and Number or	Rural Route Number, City
	Division of Vital Records, pital or Attending Physician: The law require ours after death. After this certificate has been si filled in by the timeral Directors: After this certificate bas been si filled in by the timeral director, page 2 should by	Certific	3 Suicide 6 X Could not be determined (Specify) in vehicle	, building, otto	or Town, Sta NE Wash	_{te)} 50th St ington DC	Rural Route Number City & Hates St
	Divisior Hospital or Attenct 24 hours after death Funeral Director:	_		date and place, and d	due to the cause(s) and manner as s	stated.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici Tron the Funeral Director: After this certificate see a should be detached for use as the buri	Medical	(Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinic and manner stated.	on, death occurred at	the time, date ar	nd place, and due to	the cause(s)
	(4)	Ž		nse number C.M.E.		29d. Date signed (February 5, 20	
			30. Name and address of person who completed cause of death (Item 23a)	Z., VI. E.			
1	2		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 21201			
			e 31. Date filed (Month, Day, Year) 32. Registrar's Signature				
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09-00900 Donnell Fitzgera	ld M	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legintz, Jr. State of Maryland / Department of Health and Mental Hygiene		
- omion i nagora		t- For State Certificate of Death	200	9 0507
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Deat Month		3. Time of Death
Medical Exami	ner	Donnell Fitzgerald Mintz, Jr. January 30	0, 2009	1914 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cheverly Cheverly	4c. County of Death Prince George	's
Funeral Director	,	5. Social Security Number 216-25-5870 1 N 2 F 19 Yrs. Isst birthday) If Under 1 Year If Under 24Hrs. 8. Date of Bird Months Days Hours Min. October 19 Oct	th(MM/DD/YYYY) 9. Birth 1989 Foreign er 12,	washington D.C.
d now any		10a. State 10b. County 10c. City, Town or Location Maryland Prince Georges Laure1		10d. Inside City Limits 1 X Yes 2 No
i arylan 8a-f sl	Director		0g. Citizen of What Coun	try?
the M Sa or 2		9502 Murkirk Road; Apt. 202 20708	United Stat	es
r death with the Maryland or items 23n or 28n-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.	
after	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: Bla	
hours "natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	16b. Kind of Business/li	Idustry
215-0036 be filed within 72 total Hygiene. rked other than '	Completed	12th grade Carpet Installer	Construct	ion
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MD 2 d 2 shou Ith and N n 27 is n	Ĕ	Deleathia D. Brewer (Mother) 9502 Murkirk Road; Apt. 202; La		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trammatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Resource tion Cemetery Feb. 7, 2009 22. Name and Address of Facility R. N. Hort	on Company	aryland Morticians,
Physician		23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arm failure. List only one cause on each line.		Approximate Interval Between Onset and
/Medical / xaminer		Immediate Cause (Final disease a. Gunshot Wound of Torso		Death
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Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be execut releath ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - tra	Completed		psy prior to commed? prior to commed?	topsy findings available ompletion of cause of
Re i: The lificate or, pag		25. Was case referred to medical 26. Place of Death (Check only one)	2 No 1 Ye	s 2 No
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	-		how injury occurred	
Division tal or Attendir rs after death ral Director: A	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Ru	ral Route Number, City
Divisior Bospital or Attend 24 hours after death Funeral Director: ctely filled in by the	Certification:	Suicide 6 Could not be or Town, S	State) ne Drive, District Heigh	its, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date		
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mor	
	_	O.C.M.E.	January 31, 2009	
102		30. Name and address of person who completed cause of death (Item 23a) Detricis Archica Polick MD. Assistant Medical Examiner 111 Ponn Street Baltimore MD 2120	1	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** McKelley Josephine Mary 2009 9:58 30. /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 1 F 579-44-2629 94 Director Feb 15, 1914 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits Director District of Columbia Washington TV∑Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3956 Clay Place, NE 20019 Funeral United States 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify 2 Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Practical Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Jones Virginia Ann Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tra once. John McKelley - Spouse 3956 Clay Place, NE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l Mem. Pk Feb 6, 2009 Laurel, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7 Days Clostridium Difficile Colitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Sepsis autopsy perform Thrombocytopenia 1 ∐Yes 2X XNo 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □XNatural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

3000 68760. Box P.0. Division of Vital Records, 28a-f show

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Saltimore, Maryland 21215-0036

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To the Hospital or Attence within 24 hours after death To the Funeral Director: State Registrar

Medical 29b. Signature and title of certifier

6 Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D37891

January 31, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121 Congresswood Lane #409 Rockville, MD 20852 Arasvansni, M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

FEB 0 3 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 9-00792 State of Maryland / Department of Health and Mental Hygiene Michael J. Missimer Certificate of Death Reg. No 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day January 27, 2009 Physician/ 0023 hrs Medical Examiner Missimer Michael 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 600 Admiril Drive, Apartment 515 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign **Funeral** Days Hours Months Country) 9, 1969 MD Oct. 39 Director Yrs 1 X M 2 217-78-0138 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County any Yes 2 X No Annapolis Anne Arundel MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 21401-7558 600 Admiral Dr. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) marked office than "naunal", or items event, the Medical Examiner must be Armed Forces? Never Married 2 Married 1 X Yes No Specify: White Yes 2 X No specify: Yes. Give Yea should be filed within 72 hours after and Mental Hygiene. 4 X Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retire(1) Completed Elementary/Secondary (0-12) College (1-4 or 5+) US Navy than 21215-0036 Sailor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Gouker æ Lincoln Missimer 19b. Mailing Address (Street and Number or Rural Route Number, City or Tawn, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 should been of Health and Men 50208 19th St. North C-13 Newton. IA 2305 \mathbf{E} Mary Foucher - Mother If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) timore, Removal from State Burial 2 XCremation 3 Glen Burnie, MD 2-12-2009 Crematory Atlantic Other Specify. Donation 5 22. Name and Address of Facility 21/Signature of Funeral Service Licenses Murray Funeral Home 4804 Georgia Ave. N 20011 DC. .W Washington Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or here Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death 'Medical Gunshot wound of head а Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED g physician a the burial -23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth attending por use as the past 12 months? Pregnant at time of death Other (Specify, 5 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o Yes 2 ✔ No 3 Probably 4 ð Records, P. 24b. Were autopsy findings available 24a, Was an Completed prior to completion of cause of autopsy death? performed' has certificate has ector, page 2 s 1 🗸 Yes No ✓ Yes 2 26 Place of Death (Check only one 25. Was case referred to medical the Hospital or Attending Physician: director, Other₄ Division of Vital Be Residence 6 V Other: Scene Nursing Home 5 DOA examiner? Hospital: 4 ER/Outpatient 3 Inpatient 2 1 Yes 28d. Describe how injury occurred this ٩ 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death After Subject shot Certification: FOUND: Yes 2 V No Natural Pending Jan 27, 2009 0023 hrs within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City in by the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 600 Admiril Drive, Apartment 515, Annapolis, MD Could not be 3 Suicide determined (Specify) Multi-Family Apt. 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c License numbe 29b. Signature and title of certifier January 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

0"4"2009

State of Maryland / Department of Health and Mental Hygiene 2009 05082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 1, 2009 **Physician** 9:55A. Marie Angela Milnor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June6, 1937 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min Pennsylvania 1 □ M 2 🙀 F 222-24-8780 71 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Madical Examinat must be notified at 1 ☐ Yes 2X No Beltsville Maryland Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 United States 4723 Cardinal Avenue death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Lucy Fraticelli Joseph Berotti ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27, any injury or other tra once. Health am 27 is 4723 Cardinal Avenue Beltsville, Maryland 20705 Joseph E. Milnor -husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/2/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald Vores Borgwardt Funeral Home, PA Meneld 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 day Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical **Examiner** Chronic Obstructive Pulmonary Disease 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Morbid Obesity; Obstructive Sleep Apnea; Hypertension; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Diabetes Mellitus Type II; Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I page 2 s performed? Yes 2 XNo 1 ☐ Yes 2X No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this s after death.

I Director: After this of in by the funeral di 27. Manner of Death 14 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie February 2, 2009 1)46120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
F. Delcon, M.D. 10724 Little Patuxent Parkway Columbia, Maryland 21044

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 04

Barrad

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 3:15 p M 2009 Toshiko Masugi Mary February 1, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 96 Yrs. Days 1 M 2 XXF 537-26-4298 1, 1913 Director Washington Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 208 Park Avenue, #405 20877 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ★▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 😾 No Asian Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otomatsu Hirai Tsuru Shimizu ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Masugi/Son 208 Park Avenue, #405, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State Feb. Metropolitan Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis
 Due to (or as a consequence of): /Medical **Examiner** b. Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 14 days Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abuscinan and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1XXVatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Q1 D68080 February 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 Sireesha Jalli, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1/23/2009 3:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Whipoorwill Drive 5815 Deale Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 577-03-2658 1 ☐ M 2 🙀 F Director 105 8/24/1903 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shover the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinant once. 5815 Whipoorwill Dr. 20751 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 (∑XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√No Specify: White 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Venable Harry W. Goode ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 Whipoorwill Dr. Roland Miller Deale, MD 20751 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/27/2009 | West River, MD Our Lady of Sorrows 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Serve Licensee 2 12 Ridgely Ave Annapolis, MD 21401 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specity) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1 □Yes 2 No 1 ☐Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Nesidence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely

20

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MCILWAIN -RANCES 2050 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House | HUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. Sept 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex Year) 1 M 2 F 85 1923 Maryland Director 579-36-1198 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a State 10c City Town or Location ral", or items 23a or 28a-f show Examiner must be notified at tv Yes 2 □ No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1980 Dominoe Rd. 21401 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? 1 □Yes 2 XNo Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: Specify: Black ģ 3 Widowed 4 □ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, It we medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th<u>Housekeeping</u> <u>Crownsville Hospital</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Eades Richard Johnson Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 273 Thelma Ave Glen Burnie, Md. 21061 Department of Health Important: If Item 27 any injury or other trong. John McIlwain(Son) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 1-27-09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Marine Remarks of Acid Cons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISSEMINATED WIDELY 0 **Physician** /Medical Due to (or as a consequence of): Examiner Secure fally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) MIE Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOUSE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific Name and address of person who completed cause of death (Item 23a) (Type, Print) M LICHAR 44

Registrar

State

31. Date filed (Month, Day, Year)

JAN 3 0 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 05086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 7, ^{pay} 2009 5:20 **Physician** Kyle William Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 3, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min Texas 455-04-7188 51 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director Maryland St. Mary's Leonardtown permit. Pages 1 and 2 should be filed within 72 hours after death with the It Department of Health and Mental Hygiene. I mportant: If item 27 is marked other than "natural", or items 23a or 28a-1 any injury or other traumatic event, the Medical Examinar reserved. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 22447 Armstrong Drive 20650 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Generator Technician Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delbert Clyde Miller Betty Bernice Shields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Sue Miller / Wife 22447 Armstrong Drive, Leonardtown, Maryland 20650 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February Alexandria, Virginia can Crematory 9, 2009 Alexandria, Virginia
22. Name and Address of Facility National ey Gardiner Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licenses Kenneth P.O. Box 270, Leonardtown, Maryland 20650 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a conse ruence of): Kena jeary disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 NO 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Registrar

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State

C bab-h

FEB 1 0 2009

Chandra Sajja, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

24035 Three Notch Road, Hollywood, Maryland 20636

D54346

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		State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and N rtificate of Death	lental Hygie Reg.	7009	05087
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physic		Brendan Francis Murphy		Month February	7, 2009	l2:15 p.₩.
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		22372 White Oak Road	Leonardtown		St. Mary's	
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthola	ce (State or Foreign
Directo	r	221 - 16 - 9984	Montrio Bayo Houro Minin	02/23/193	0 Delav	
pu:		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		100	I. Inside City Limits
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the M	Director	Maryland St. Mary's Leonardtow	n 10f. Zip Code	10a	. Citizen of What Countr	v?
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eath rs 23	Funeral	22372 White Oak Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20650 Was Decedent of Hispanic Origin? (Sp		nited State 14. Race - American	
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VICE Ment Ment arkec	2	Cecil E. Murphy	Veronica	Jennings		
2 sho and is mi		19a. Informant's Name/Relationship (Type. Print) 19b. Mailir	ng Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip C	Code)
and and n 27 n 27 ner tr			Kline Drive, Leo			
DAILLINOTE, INICITYIATIO ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprisit met mast be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	natory or other place)	Date 20	c. Location - City or Tow	n, State
Dallimor Dermit. Pages Department of mportant: If It any injury or or		4□Donation 5□Other (Specify) Brinsfie	ld-Echols Cre02/15	72009 Ch	arlotte Hal	L1, MD
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n gv= 4	a	Edward N. Brinsfield, Jr. M00052 22	2955 Hollywood Roa	ad, Leonar	dtown, MD	20650
		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate nterval Between Onset and Death
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/Medica	-	resulting in death) Due to (as a consequence of):				
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He law he law	를			autopsy performe	prior to com	pletion of cause of
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Physical display	<u>ا</u>	1 ☐ Yes 2 No Pospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiel 27. Manner of Death 28a. Date of Injury 28b. Time o	nt 3 DOA 4 Divursing H	28d. Describe how		
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ISI Atten deatl ctor: y the	ical	3 Suicide 6 Could not be 380 Place of Injury At home form et		28f. Location (Street	et and Number or Rural	Route Number,
DIVISION I or Attending after death. Director: Afte	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
UNISION OT VITAI HECOTIS, P.O. BOX or to the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal				
e Ho: 24 h e Fur letely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one) and manner stated.				
ompl	Me	29b. Signature and title of certifier	29c. License number	_	. Date signed (Month, D	ay, Year)
1		-ABran	D 4706	0	2.9.9	
10m		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
13			e Court, Leonardt	own MD '	20650	
5	State	and the second s		CALL PULL		
Regi		31. Date filed (Month, Day, Year) 732. Hegistrar's Signature				

05088 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** February 9, 2009 1420 Sue /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22372 White Oak Road St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ X F Yrs. 70 18, Director 204-30-1248 1938 Indiana Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If New 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Modern Examiner must be notified at 1 □Yes 2XTXNo Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number USA 22372 White Oak Road 20650 Completed by Funeral s filed within 72 hours after death val Hygiene.

other than "natural", or items 23: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No Specify Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 Is marked ott Be Albert Vera Hurt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Patrick B. Murphy/Son 41599 Kline Drive, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 02/12/2009 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) of uneral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tas **Physician** reas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No this certificate 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) the funeral . Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 470 66 10.9 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court, Leonardtown, MD 20650

Registrar

31. Date filed (Month, Day, Year)

FEB 1 1 2009

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

DHMH 17 Rev 1/2001

32/Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Mark Barbara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O **Physician** 2.00 0 YARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD HOWARD COUNTY GENERAL HOSPITA COLUMBIA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □ M 2 🕏 F 1-6-1918 PA Director 198-16-5660 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at agines. Director Douglas 1 Tyes 2 X No NV Minden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1267 Bronco Circle 89423 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | If Yes, Give Year or Dates: 2 **K**o 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mike Ender Kata Paplich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930 Great Star Dr. Unit 308, Clarksville, MD 21029 Richard Shrout / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2-4-2009 Ardent Cremation Hanover, MD 21. Signal up Jun Ja Se vice Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 23a. Part Defice the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or yeart failure. List only one cause on each line.

Immediate Caule (Fin disease or condition resulting in death)

a. TSCHEMIC COLITIS Ther 4112 Old Columbia Pike, Ellicott City, MD 21043 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of). Examiner HYDERTENSION YE YES Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ ATRIAL FIBRILLATION, CHRONIC OBSTRUCTIVE ALLMONARY 1 Yes 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DISEASE 24a. Was an ARTERICSCIEROSIS autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2. and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

8186 LARKBROWNRD, SUITE 201 ELKRIDGE, MD JOIEPH F. GIBBONS MD

138296

31. Date filed (Month) 2009

32. Registrar's Signature parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05091Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30, 2009 1:00 P^M January Robert Tyler Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 167 Midsummer Drive If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months 1922 Pennsylvania 162-14-9435 June Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1□Yes 2□No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code with 1 21702 United States 167 Midsummer Drive Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?
1 英Yes 2 □ NowWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mayes 2 ☐ If Yes, Give Year or Dates: should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White ρ 3₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Central Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Agency Intelligence Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles D. Martin Alice B. Morton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Health a 103 Ali Drive, Middletown, MD 21769 Roberta Bevington / item 27 20b. Place of Disposition (Name of cemetary, crematory or other place)
Restinavell
Memorial Gardens Department of He Important: If iten any injury or othorone. 20c. Location - City or Town, State Date 20a. Method of Disposition 7. 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) 2009 Frederick, Maryland 22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Signature Licens 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death 23a. Par(1. Enter the disease, or conshock, or heart failure. List only Immediate Cau (Final disease or condition resulting in death) **Physician** Hours Myocardial Ischemia /Medical Due to (or as a consequence of): Examiner Month Lung Cancer Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation s after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hegazi, M.D.

46 B Thomas Johnson Drive, Frederick, MD 21702

32. Registrar's Signature EMELLA

Registrar

D 44164

Feb. 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 19

ed Date 2.13.09.WCHD. SLU Cortificate of Death

		1	State of Maryland / Departmen state Amended Date, 2.13.09, WCHD, SLU Certificate Registrar	it of H <i>e of L</i>	lealth and Mei D <i>eath</i>	ntal Hygien Reg. N	2000	05092
	Physicia	_	. Decedent's Name (First, Middle, Last)		2.	Date of Death Month	ay Year	3. Time of Death
and a	/Medic	al	Je m	Town, or	Location of Death	4	c. County of Death	
	LAGIIIII		Peninsula Regional Medical Ctr. S		Sbury If Under 24 Hrs) 8.		Wicon	nico place (State or Foreign
	Funeral Director		Social Security Number Social Security Number Social Security Number Social Security Number 18 M 2 F 7. Age (In yrs. last birthday) Yrs. Months		Hours Min.	Date of Birth (Month, Day, Yea 7 - 3 - 1	r) Cou	eylend
	7		Jsual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Maryla	.	MARGIANE Wicomico Quantico					1 ☐ Yes 2 ☑ No
	death with the Maryland ims 23a or 28a-f show	Director	0e. Street and Number			10g. (Citizen of What Cou	ntry?
	ns 23a	Funeral	70.700	dent of H	ispanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No-	14. Race - Ameri	can Indian,
5-0036	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marilen Eventinal must be notified at one.	by	Armed Forces? 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: ₩ ₩ ✓ ✓ 1 □ Yes		Specify:			ACK
50	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of wo	al Occup ork done d se retired	ation during most of working I)	16b.	Kind of Business/Ir	idustry
212	d withir giene. er than the M	Somp	Elementary/Secondary (0-12) College (1-4or 5+)				Nene	
yland	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last) HCRGCE MOORE		18. Mother's Name (F	First, Middle, Maid (今日)		
	should nd Mer marke imatic	우		s (Street	and Number or Rural F			p Code)
Z Ž	and 2 ealth a n 27 is ner trai		PORINGA MOORE - WIFE 22102 Ro	149)	OAK ROAD		Location - City or T	21856
၂ ၂ Baltimore	Pages 1 ment of H ant: If Itel lury or otl			urch Urch	Cem +7	09 B	MANTICO,	Maryland
Balt	permit. Dupart Import any inj		21. Signature of Funeral Service Licensee 22. Name at Stewart 22. Name at Stewart	art.	FUNERAL	Home 8	21 WES Rd	Salis. Md
			23a. Part 1. Enter the disease, or complications that caused the death. 30 not enter the most shock, or he in failure. List only one cause on each line.	de of dylr	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or selection)	-	-	reaso	-	900-
	Examiner	L	Sequentially list conditions, b.	10	2004			goers
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):					
,8760,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
687	tificate ig phys as the	ledical	d					
O. Box	Attending Physician: The law requires that the death certific retain. retain. ector: After this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other (s		ey		23d. Date of deli Month	very Day Year
	w requires that the di been signed by the should be detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying.	cause giv	ren in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ords	equires een sig ould be	ted b				1 ☐ Yes		obably 4 🗌 Unknown
Division of Vital Records,	sician: The law r certificate has bu rector, page 2 sh	Completed				24a. Was an autopsy performed 1 □ Yes 2 ☑	? death?	topsy findings available completion of cause of 2 □ No
Vita	sician; certific rector,	B	25. Was case referred to medical examiner? 1 Yes 2 Mo	Oth	26. Place of Death (e 6 □ Other (Spec	
οt	ding Phys h. After this funeral din	n: To		28c. Inju Wor		d. Describe how in		пу)
isior	il or Attendin after death. I Director: Af d in by the fur	Certification: To	2 Accident investigation 3 Suicide 6 Could not be	1 🗆]Yes 2□No		t and Number or Ru	eral Route Number,
Div	i i i i i i					City or Town, Si		a ototod
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurre 2 ☐ Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my	opinion, death occurred	at the time, date	and place, and due Date signed (Month	to the cause(s)
	or with	2	29b. Signature and title of certifier	ec. Licens	se number	S 290.	3/8 P	, vay, 10a1)
	1,0eg		30. Name and address of person who complied cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 200	Ci	vic Aue.	Salis	bury	MD 21804
	St. Rus ist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1				

DHMH 17 Rev 1/2001

ORIGINAL

09-00844 Lamont Mitchell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mont Mitchell		State of Maryland / Department of Health and Mental F For State Certificate of Death		g. No. 200	19 0509
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledical Exami	ner	Lamont C. Mitchell Jr.	Month January 28	, 2009	1940 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 504 Delaware Avenue Salisbury	atn	4c. County of Deat Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		(MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
Director		214 40-2184 1XM 2 F 3 Yrs. Months Days Hours M	in. 11/3	1977	ountry) MD
>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	The z		10d. Inside City Limits
ow any					1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	untry?
the Ma a or 2	Dire	119 Justice Ave 21804		U.S.A	
h with	Funeral	11. Marijal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (14. Never Married 2 Married Armed Forces? 15. Was Decedent of Hispanic Origin? (16. Yes, specify Cuban, Mexican, Puer		14. Race - Ame White, etc.	erican Indian, Black,
er deat or ite		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	lack
urs aft tural" amine	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	s/Industry
6 172 ho an "na cal Ex	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	retired)	Rack	+
5-0036 led within 72 Hygiene. other than the Medical	Comple	2+ Arch Lobs ter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle, N	Maiden Surname)	rarti
21215- uld be filed Mental Hy, marked or	BeC	Lamont C Mitchell SR Cath	ney 7	R. Jone	S .
e, MD 21215-0036 He and 2 should be filed within 72 hours after death with the Maryland Heath and Moutal Hygiene, Hen 27 is marked other than "natural", or items 23a or 28a-f short rannmatic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Author) 19c. Mailing Address (Street and Number of Author)	0 1 1		te, Zip Code)
a = a = = = = = = = = = = = = = = = = =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City of	or Town, State
Baltimore, permit Pages I al Department of He Important: If ite	l	1 XBurial 2 Cremation 3 Removal from State crematory or other place)	10/200	1/1/	MN
Baltimore permit Pages I Department of B Important: If i	- 3	4 Donation 5 Other Specify: Opening 11 22. Name and Address of Facility	1 1/2009	an with	abella Street
Balti permit. Departn Imports injury o	ł	Man toll N. Bennie Smith Fune	ral Home	Sollishar	1 MD 21501
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Intraoral Gunshot Wound Due to (or as a consequence of):			Death
		Sequentially list conditions. b.	-		
	iner	if any, leading to immediate Due to (or as a consequence of):			a.
it sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
0, the executed sician and burial - transit		d. UNPENDED AMENDED	<u></u>		
50, te be ex nysician	Aedical	IF FEMALE: 23c. If yes, outcome of pregnancy	_	23d. Date of delive	ery
Sox 6876 leath certificate e attending phy for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant in the	gnancy	Month	Day Year
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri-	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
that the de sed by the detached f	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
S, P.O. uires that the signed by defeach	ed by		1Yes		autopsy findings available
cords law requi	Completed	Ų <u></u>	autop		o completion of cause of
	Com		1 🗸 Yes		Yes 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nu		Residence 6 🗸 Ott	ner: Scene
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been s sely filled in by the funeral director, page 2 should I	ı: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe Subject sho	how injury occurred	
F # . ^ 2	atior	1 Natural 5 Pending 2 Accident Investigation Investigation			
Division pital or Attendir ours after death. leral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S		Rural Route Number, City
ospital hours uneral		29a. Certifier 4 Contifuing Physician: To the best of my knowledge, death occurred at the time, date and place.			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, date	and place, and due to	the cause(s)
- F & F &	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
acol		Man Brasse (M) O.C.M.E.		January 29, 20	
12/1		30. Nam and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201		
	tate	31 Date filed (Month Carly ex) 4 32. Resistrar's Signature			
Regis		FEB 0 4 2009 Chrus B. Jakes			

Please Type or Print in Black Indelible in Place and 29d per phys. Good 2/19/09 Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 05094 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Winifred Amy Myerly 7:22 P M February 10, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Julia Manor Health Care Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 3/2 F Yrs. 83 Director 214-09-8340 Jan. 11,1926 Bermuda Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 √2 Yes 2 □ No Maryland Washington Smithsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 3 Blue Mt. Estates U.S.A. within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the page." Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Health Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Hollis Teresa O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gleason (Daughter) 11803 Allegany Crt. Smithsburg, Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 13, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783)AUIS Lee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical the use as § IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 → Thknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed certificate 1 Yes 2 No 2/2 No Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Attending 1 Natural 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 February 11, 2009 oral 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSAED ARID

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Hagirstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	tificate of	Death		Reg. No.	109	02032
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
	/Medic		DAVID OWEN MENCH				FEBRUA	RY 12		
	Examin	er	4a. Facility Name (If not institution, give street and number) 21905 Yerkey Rd。		4b. City, Town, o	r Location of Death	1	4c. Cou	nty of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	nplace (State or Foreign
	Funeral Director		216-56-0838 X M 2 F 60	Yrs.	Months Days	Hours Min.	Aug 1	7 Year) 94	8 Mar	yland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town online						44.1.1.1.00
	arylar show	ō		k Ha						10d. Inside City Limits 1 ☐ Yes 2 X No
	the M 28a-f notifie	Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	
	3a or		21905 Yerkey Rd.		21661			U.S.		
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.0.6	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No	. 14. F	Race - Amer	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 Married 1 Married 2 No 196	1 X Yes 2 No 1900 If Yes, Give 1070 1			o ritoding oto.)	Black, White, etc. Specify: White		
Maryland 21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	ent's Usual Occup	oation during most of wor	kina	16b. Kind of	Business/I	ndustry
2	ithin 7 ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retired Cerman	d)	ning .	0-1-6	T3]
7	iled w Hygier Iher th		1 2 17. Father's Name (First, Middle, Last)	wat	.erman	18. Mother's Nan	ne (First Middle			loyed
anc	2 should be filed and Mental Hygi is marked other aumatic event, t	To Be	Ralph Mench				Kendal		umoj	
37	should and Men s marke umatic	Ĕ		19b. Mailin	g Address (Street				vn, State, Z	ip Code)
	and 2 ealth a n 27 is ier trai		Susan Mench (wife)	2190	5 Yerke	ey Rd. F	Rock Ha	11, M	D. 2	1661
altimore,	of Hear		1 XBurial 2 Cramation 3 Removal from State	netery, ciren	sition (Name of natory or other plac		Date	20c. Locatio	n - City or T	Fown, State
Ę.	: Pages tment of I tant: If Ite		4□Donation 5□Other (Specify) Wes		Chapel					l, MD.
Ba	permit. Pages Department of Important: If I any Injury or once.		21. Signanda Guneral Service Licens M0 0 5 1	0 1	alena Addr 18 West	funeral Cross	Home o	f Ste	phen	L Schaech 21635
			23a. Part. Enter the disease, or complications that caused the death. I shock, or pearl failure. List only one cause on each line.						.115	Approximate Interval Between
	Physician	Ĥ	Immediate Onise (Final disease or condition		ARCIN				- 1	Onset and Death
	/Medical Examiner		Due to (or as a consequent	nce of):						r 1
В	Exa	<u>.</u>	Sequentially list conditions, if any leading to immediate gause. Enter Underlying		7				-	5 443
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
o,	exection and and rial-tra	Еха	resulting in death) Last C. Due to (or as a consequent							
68760,	ate be nysicia ne bu	ical	d							
	ertifica ing ph e as tl	Medical	IF FEMALE:							
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pt pregnancy	У			23d. Date of delivery Month Day Year			
Ö	the de	Physician/	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown	п эц	Other (specify) _					
Ω.	s that ned by		Part II. Other significant conditions contributing to death but not resulting	ng in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to	the cause of death?
rds	quire; an sign	ed by	GI Bleeding, Hypertusion	<u> </u>			10,	Yes 2 No	3 □ Pro	obably 4 □Unknown
ပ္ပ	law re as bee 2 sho	Completed					24a. Was		b. Were aut	topsy findings available ompletion of cause of
<u> </u>	Physician: The lay this certificate has al director, page 2	Com					perfo 1∐ Yes	rmed? 2 No	death? 1 □ Yes	2 No
Vita	iclan: Sertific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		l Oth	26. Place of Dea	th (Check only o	nne)		
or	Attending Physician: r death. ector: After this certifics by the funeral director, p	. To	1 Tes 2 Line 1 Impatient 2 LER	l/Outpatient Bb. Time of		4 Li Nursing H	ome 5 Resident			ify)
on	iding th. : After	tion	Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injur Wor M 1 🗆	k? Yes 2∐No	EOG. DOGGING	iow injury occ	MITCU	
Division or Vital Records,	Atter er dear ector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office	-	28f. Location (8	Street and Nu.	mber or Ru	ral Route Number,
	itai or rs afte rai Dii led in	Cert								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier (Check only one) 1 Certifying Physiclan: To the best of my knowle check only one) Medical Examiner: On the basis of examination and manner stated.	dge, death	occurred at the time times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the times of the control occurred at the control	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens			29d. Date sig	ned (Month	, Day, Year)
			NO NO		5	51735		2	13)	70
			30. Name and address of person who completed cause of death (Item 23		,		1			
			Frederick Delboy, M.D. 660			ill Rd.	Cheste	ertown	MD	21620
	Sta Registr		31. Date filed (Month, Day Year) 2009 33 Registrar's Signatur.	Spa	Mad					

Dr

State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:20 PM NOBLE 26,200 RETHA anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-20-1925 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F Months Days Hours Min WASHINGTON, DC 83 Director 579-32-6736 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is insalical Exercises must be notified at 1XYes 2 No Director MD P.G. BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15005 HEALTH CENTER DRIVE 20716 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedon. Armed Forces? 1 □Yes 2 → No 1 □ Never Married 2 □ Married Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: BLACK ۾ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7% th and Mental Hygiene. 7 is marked other than "ns Elementary/Secondary (0-12) 12th College (1-4or 5+) ADMINISTRATIVE ASSISTANCE FEDERAL GOV'T. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TARRANT WILLIAM HENRY PIERCE ROSEBUD ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health an Important; If Item 27 is any injury or other trau once. ANN KEELING - DAUGHTER 407 AVIAN FOREST DR., STOCKBRIDGE, GA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Remo RIVERDALE PK CREM. 2/3/2009 RIVERDALE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility RONALD TAYLOR, II FUNERAL HM 21. Signature of Fund Service Licenses 10583 MIDDLEPORT LANE, WHITE PLAINS, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one vause on each line. Immediate Cause (Final EPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury law requires that the death certificate be executed DI AB ETES sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 □ 1 16 9 Unknown s been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The performed? certificate I 2 - No 2 🔼 No 1 ☐ Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 767210 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AS 100 UM. SHS Good Luck Rd., Lacham, 2667 31. Date filed (Month, Day, Year) State

Registrar

Retha

FEB 0 2 2009

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examine Month Day February 6, 2009 0554 hrs Arnoldo Reyes Nitsch 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7205 Hitching Post Lane Hyattsville Prince George's 5. Social Security Number Puneral If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Director Months Days Hours None 1 X M 2 43 Yrs 1966 03 Guatemala Usual Residence of Deceden Ę 10a. State 10b Jounty 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 Prince George's Hvattsville Pages 1 and 2 should be filed within 72 hours after death with the Maryland rem of Health and Mental Hygrone.
nut: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7205 Hitchning Post Lane 20783 Guatemala Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black must be 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specifyGuatemalan Specify: White <u>ج</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 6th Painter Self-Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Juan Reyes Mercedes Nitsch 19a. Informant's Name/Relationship (Type, Print) Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy J. Reyes Menjivar 7205 Hitchning Post Lane Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial Cremation 3 crematory or other place) 2 Removal from State Department of Important: 02-15-09 Donation 5 Otner Family Cemetery Guatemala 21, Signature of Funeral Servi License 22. Name and Address of Facility W.H. Bacon FuneralHOme, Inc. 3447 14th St, N.W. Washington DC 20010 I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ailure. List only one cause on each /Medical Between Onset and Death immediate Cause (Final disease Isopropanol intoxication kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical 23a,27,28a-f, per ME g889 3/3/09 XUNPENDED AMENDED attending physician or use as the burial requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 V Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 2 1 ✓ Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject ingested rubbing Certification: Natural Pending Yes 2 X No Within 24 nouse
To the Funeral Director: Fd 5:30 Fd 2/6/09 alcoho1 2 ath Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 205 Hitching Post 3 6 X Could not be Suicide determined (Specify) Homicide residence Lane Hyattsville. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E February 7, 2009 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 FEB 1 0 2009 32. Regist State Registrar

DHMH 17 Rev 1/2001 OCMF 2006

DHMH 17 Rev 1/200:

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year : 35 A M CONSTANCE т. OUTTEN rebruor 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Janokin Manor Somerset Princess Anne 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 75 Director 220-28-2096 Nov. 30, 1933 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Item Predict Examiner must be notified at Director 1 ☐Yes 2 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 26782 Old State Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene... Important: If Item 27 Is marked other than "any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Hairdressing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Travis Tawes Maude Tawes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Lynn Wilson (Daugherty) 6157 Duckweed Court - Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/09 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park Crisfield, MD 21. Signature Pupa al Service Licensee
Robert H. Bradshaw, The permit. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Liver lancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4100 Sequentially list conditions, if any, leading to immediate cause Enter the cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. led by the a detached f 9 Unknown 9 Unknown cate has been signed, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. DIVISION sheet NATESAN vel 31. Date filed (Month, Day, Year) 32. Registrar's Signature Denve B. facks Registrar

:35am

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February

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day NI 1 Year

Physician ANNIE

1 - For State Registrar

Physicia /Medic		ANNIE M. POWELL	Januar	× 23 2009	4:16 PM				
Examin	er	4a-Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Do	4	4c County of Death	DENRIGES				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 F		h 9. Birthpl y, Year) 53 Count	lace (State or Foreign				
ie Maryland 8a-f show	ector	10a. State PRINCE GEVREES NEW CARROLLT	ON	10	Od. Inside City Limits Yes 2 □ No				
th with th	Funeral Director	10e. Street and Number 85 TH AVENUE 20784	4	10g. Citizen of What Count U.S. A	,				
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show filest Evaninal to rediffed at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	an Indian, tc.				
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be neithed at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	vorking	16b. Kind of Business/Indi					
Maryland 2 d 2 should be filed the and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) William Powell DLO		ATTHEW	-				
e, Mary 1 and 2 sho Health and em 27 is me ther traums		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of SHARON L. POWELL SISTER 6/16 857H AVENUE	Bural Route Numbe	r, City or Town, State, Zip (ARROUT O/ 24LAND 20	Code) 784				
Pa Pa		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 4 Donation 5 Other (Specify)	Date 30-2009	20c. Location - City or Tov	on, State				
Balti permit. Departri Importa any inju		Lucare med 3005 12TH ST. N.	E. WASH,	INGTON, DC					
Physician /Medical Éxaminer		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Initial diate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	liac or respiratory arr		Approximate Interval Between Onset and Death				
0, executed an and rial-transit		ysician/Medical	ysician/Medical Exa			Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hrem's the Chronic distribution of the cause of the cau			
D. Box e death cer the attendir						IF FEMALE: 23b. Was decedent pregnant in the past 12 profiths? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		, 23d. Date of deliver Month	ry Day Year
Pat Pat P	ا ۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to the	e cause of death?				
The Is ate ha	Completed		24a. Was ar autops perform	prior to commed?	sy findings available pletion of cause of				
of Vital Physician: 7 r this certifica	To Be	Hospital:	eath (Check only on	e) ence 6					
Division of to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8 Injury 8 Injury 9 M 1 Yes 2 No		ow injury occurred					
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To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place and place and place and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and pla	ace, and due to the concurred at the time, do	ause(s) and manner as sta ate and place, and due to t	ated. the cause(s)				
To the within 2 To the comple	Σ	29b. Signature and title of certifier 29c. License number 743446	29	9d. Date signed (Month, Da anuary 35	ay, Year) 2009				
125		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rointon Farch For M. U. 98D/ Ctorgia Ave Suit 3-3 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2 Silver Spr	ing, mo. 20	902				
Stat Registra	7	FEB 0 2 2009 Severe S. Saves		V					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Charles George Petty January 2009 26, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min, 1 XM 2 ☐ F 042-26-8978 74 12, 1935 Waterbury, Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Suitland 1 x Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 Sunset Lane 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 ₩ Married 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellis Petty Dockiner Sturdivant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Petty / Wife 2918 Sunset Lane Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Pine Grove Cemetery Feb. 2, 2009 4 Donation 5 Dother (Specify) Waterbury, Ct. 21. Signature of Funeral Service License 22. Name and Address of Facility Alexander S. Pope / P.A. 5538 Mariboro Pike/Forestville, Md. 20747 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 JI W disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 D Unknown 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

Exami sician and burial-trans aftending physiciar Physician/Medical as the l nse 힏 been signed by the should be detached ð Completed has page 2 certificate Be မှ

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law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral Certification: in by the npletely filled Medical

Part II. Other significan	t conditions co	ontributing to death but not res	23e. Did tobacco use contribute to the cause of death?										
					1 Yes 2 No 3 Probably 4 Unknown								
					24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No								
25. Was case referred to examiner?	o medical		26. Place of Death (Check only one)										
1 Yes 2 No		Hospital: 1 ☐ Inpatient 2√	ER/Outpatient 3 □	me 5 Residence 6 Other (Specify)									
27. Manner of Death 1 ☑ Natural 5 2 ☐ Accident	Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1₹ (Check only 2□	Certifying Phy Medical Exam	ysician: To the best of my kno liner: On the basis of examina	wledge, death occurr tion and/or investigati	ed at the time, date and pla on, in my opinion, death or	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)								

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

らっつっへいか

7503 Surratts Rd. Clinton, Md. 20735

D0064055

29c. License number

29d. Date signed (Month, Day, Year)

9

31. Date filed (Month, Day, Year) FEB 0 2 2009

Eric McDonald, M.D.

29b. Signature and title of certifier

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Annie L. Pope 4:05 PM 31 2009 4a. Facility Name (If not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death P.G. Clinton 9402 Pella Place Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 - 8 - 1914 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Months Hours Min 1 □ M 2 🖸 F 94 141-16-2130 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD. P.G. Clinton 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 U.S.A. 9402 Pella Place 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify. Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Govt. Elementary/Secondary (0-12) College (1-4or 5+) Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Simpson Oliver Hawthorne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9402 Pella Pl. Clinton MD. 20735 19a. Informant's Name/Relationship (Type. Print) Daughter Barbara P. Bennett 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Berlin N.J. 2-7-2009 Berlin Cemetery 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash. D.C. 21. Signature of Funeral Service Licensee 20011

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

er than "natural",

of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, It's M

permit. Pages 1
Department of H
Important: If ite
any injury or ot
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Director

by Funeral

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

been signed by the attending p should be detached for use as this certificate has al director, page 2 a within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	rotic Cana	e of dying, such as cardia			Interval Between Onset and Death				
miner	Sequentially list conditions, any course the Underlying Cause (Disease or injury that initiated events	bto (ux as a consequence	ence ofj:								
dical Exa	resulting in death) Last	Due to (or as a consequence of):									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1									
ed by Pr	Part II. Other significant conditions of	contributing to death but not resu	lting in the underlying ca	ause given in Part I.	23e. Did tobacc		o the cause of death?				
Complet					24a. Was an autopsy performed 1 □ Yes 2.2	prior to death?	utopsy findings available completion of cause of				
Be	25. Was case referred to medical			26. Place of De	ath (Check onl one)						
	examiner? 1 ☐ Yes 2 ∰No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DC	A Other: 4 I Nursing H	Home 5 Residence	nce 6 Other (Specify)					
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?		28d. Describe how in	8d. Describe how injury occurred						
Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory,	office	and Number or R ate)	ural Route Number,					
Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a death occurred at the time, date and place, and due to the cause(s) and manner as a death occurred at the time, date and place, and due and manner stated.										
M	29b. Signature and title of certifier		290	. License number	29d.	Date signed (Moni	th, Day, Year)				

State Registrar

11701

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended #23B per MD FCHD, JV **Dersificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EMMA BERTOTHY PRANULIS 1, P M February 2009 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 046-10-8310 97 Director March 16, 1911 Connecticut Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Ves 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2531 Bear Den Road 21701 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed whand Mental Hygiel Accountant Accounting traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any injury or other traumatic ev Ladislaus Bertothy ျှ Susan Bitto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Pranulis / Daughter 2531 Bear Den Road, Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Calvary Cemetery 02/14/2009 Naugatuck, Ct 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-transit Exam and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a detached ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>۾</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Certification: or Attending 1 Naturel 5 Pending (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO DLIVE, FREDERICK, MD -21702

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Clarissa Alexis Panky 2009 Febauray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Qeath 4b. City, Town, or Location of Death **Examiner** SAUSBUR TENINSULA HICAMIC REGIONAL Center If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 66 March 26, 1942 Maryland Director 216-70-2287 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show Director 1 FYes 2 No Snow Hill Worcester MD the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21863 205 E. Cypress Lane P.O. Box 165 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23.
Int or other traumatic event, Inc. Medical Exp. The result of the present of Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elwood Townsend Rachel Briddell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205E. Cypress Lane - P.O. Box 165 Snow Hill, MD 21863 John Panky/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tt☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2009 Bishopville, MD Curtis UMC Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, MD 21801 Jolley Memorial Chapel, P.A. - 1213 Jersey Road 23a. Parff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unsease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> HIM 2 ☐ O 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed DM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has lirector, page 2 s autopsy perforn 2 X No 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 KER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature H-50497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Snyder, m.D. PRMC 100 E Carroll St. PRMC. Salisbury mD21801 32. Fegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 Month 2009 James W. Queen January 10:18P ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BWMC Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 8. Date of Birth (Month, Day, Mar 7 5. Social Security Number ^{Year)} 1926 Hours Months Days 1**X** M 2□ F Màr 218-12-9603 82 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MarylandAnne Arundel 1 ☐ Yes 2X No Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2490 Lee St. 21054 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Army & Air Force Elementary/Secondary (0-12) 7th College (1-4or 5+) Mechanic Exchange Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Queen Sr. Dorothy Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Springhill Way Gambrills, Md. Sylvia Pack(Daughter) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Macedonia Church | 1-27-09 Odenton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Anneme Reads of &cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee Farry 12, Been MOVY83 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestine disease or condition resulting in death) 1 week Due to (or as a consequence of): mand hear Hypertension Due to (or as a consequence of) 1 work EtTtu sion Revoal Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 185 Yes 2 □ No 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one)

Physician /Medical Examiner

attending physician and for use as the burial-transi

signed by the a

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page 2 has

certificate

o the Hospital or Attending Physician: thin 24 hours after death. I the Funeral Director: After this certific impletely filled in by the funeral director,

To the within 2

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

Department of Health an Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

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Funeral

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedical Examination ust be motified

and Mental Hygiene.

filed within 72 hours after

Pages 1 and 2

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, bearing to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

27 Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUSGIFER

Hospital: 5 ☐ Pending investigation

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Glen Burnie, Md. 21061

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MICZ9

6 ☐ Could not be

determined

D0040519.

29d. Date signed (Month, Day, Year) 1-26-09

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Madison

1401

09-00772

Theodore James	1-	For State	of Maryland	/ Depa <i>Cer</i>	rtment of tificate of	Health Death	and	Mental	Hygien	e Reg.	No	20	0 (3(151		
Physicial	n/ 1	egistrar . Decedent's Name (First, Middle,Las			(-1)	of Death	Day Year 0000 hro										
Medical Examin	er	Theodore James				4c. County of Death											
1	4	a. Facility Name (if not institution, given 7099 Indian Head Highwa	b. City, Tov Bryans	Road		Charles											
Funeral		6. Social Security Number 6. S	ex 7. A	ge (In yrs. la	last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir					Foreign Andrew							
Director		217-80-7226	%M 2 F	45	Yrs				03-	-09-1	963	1 00	Junity)	AFB	<u>, MD</u>		
>		10c, City, Town or Location												. Inside C	City Limits		
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ryłand a-f sh t once	황	10e. Street and Number	10f. Zip C	ode		100	0g. Citizen of What Country?										
or 28	Director	4685 Port Tabacc		0662	USA												
eath with the Maryland items 23a or 28a-f show ust be notified at once.		11. Marital Status	ital Status 12. Was Decedent Ever in U.S. 13. Was						as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)						 Race - American Indian, Black, White, etc. 		
death or iten	Funeral	1 Never Married 2 Marrie	1 Yes	2 * No	Yes 2*				Specify: White								
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hours	te g	Elementary/Secondary (0-12)	during most of working life. DO NOT use retired)								Private Industry						
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5-00 led will tygien of the M		17. Father's Name (First, Middle, La	st)				1		Name (First, ary C.		aiden Surnam	e)					
121 J be fil ental l arked	Be	James L. Riggs 19a. Informant's Name/Relationship	(Type Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rural R	oute Num	per, City or To	wn, Sta	ite, Zip	Code)			
D 2 should and M 7 is m	٩	Connie S. Riggs			4685	Port	Taba	acco	Road N	anjer	noy, MI	20	662	2			
Baltimore, MD 21215-0036 permir Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important If tiem 27 is marked other than "natural", or items 13a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a Method of Disposition			. Place of Dispo crematory or c	sition (Nam	e of cen	netery,	Date		20c. Location						
nore last last last last last last last last		1 Burial 2 Cremation		State	dar Hi		nete:	ry	01-30-	-09	Suitla	ınd,	Ma	ıryla	ınd		
Iltin nit P. artme sortan		21. Signature of Funeral Service Licensee 22. Name and Address of Facility										ID 20	1746				
Per Per Julia		Shawn C Aylesworth M01521 June Cedar Hill FH 4111 PA Ave. Suittland, FID 20740															
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calculated respiratory arross, such as calculated respiratory arross, and the Between Onset at Between Onset at Death															
/ aminer	h N	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):															
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.		Due to (or as a consequence of):													
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ords, P.O. Box 68760, wrequires that the death certificate be executed seen signed by the attending physician and should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou			Fetal death	3	Ectopic	pregnancy		Month		Day	,	Year		
x 68 h certi tendin use as	cial	past 12 months?	7	nt at time of		Other (Spe	cify)				1						
Bo) e deatl the att	hys	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
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COFC law re has be	월	performed?											h? Yes	. 2			
tal Recol	් ්	25. Was case referred to medical					26.Plac	e of Death	(Check only								
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n of Vii ling Physi After this	⊢	1 ✓ Yes 2 No 27. Manner of Death	of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot														
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Division of Vital Records, tat or Attending Physician: The law requirers after death. Director: After this certificate has been silled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Certification:	3 ✓ Suicide 6 Could	28e. Place of Injury - At home, farm, street, factory, office building, et						or Town, State) 7099 Indian Head Highway, Bryans Road, MD								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici compleely filled in by the funeral director, page 2 should be deached for use as the burit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
To the	Medical	29b. Signature and title of certifier	29c. License number					29d. Date signed (Month, Day, Year)									
		Santof Prest	will min		O.C.M.E. Janu					January	nuary 27, 2009						
		30. Name and address of person		se of death (Item 23a)	44. =	·	5	nore MD	24204				_			
UZ 5	100	Pamela E. Southall, M					n Stre	et, Baltir	more, MD	21201							
Peni	Stat		32. Re	egistrar's Sig	native Saves	•											

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	rice Robinson, Jr. State of Maryland / Department of Health and Mental Hy 1- For State Registrar Certificate of Death											Reg. No. 2009 0510						
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Medical Examin	ner	DARRYL MAURICE 4a. Facility Name (if not institution)				_	4h City	Town or l	ocation of Death	Month January	31, 20	009 c. County of E		00011113				
		Southern Maryland H	. 0				Clint		ocation of Death	Prince George's								
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Auth th		2205 Ramblewoo 11. Marital Status	as Deced		anic Origin? (Sp				American	Indian, Black	ζ,							
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after c	by F	3 Widowed 4 Di	vorced If Yes, Giver Dates:					2 X No		Specify: Black								
2 hours afte "natural", Examiner	ed k	15. Decedent's Education (Spe							on (Give kind of w DO NOT use retir		16b.	. Kind of Busir	ness/Indu	ustry				
36 in 72 han "	plet	Elementary/Secondary (0-12)) Colle	ege (1-4 or 5	o+)						_							
5-0036 iled within 7. Hygiene 1 other than	Completed	17. Father's Name (First, Middle	e, Last)			Labor	er	1	8.Mother's Name	(First, Middi		<u>rivate</u> n Surname)						
215 be file mtal Hy rked o	Be	Darryl Maurice		on Sr					Renee T.	Trvi	no							
21 ould double d	5	19a. Informant's Name/Relation				19b. Maili	ng Addres		and Number or R			City or Town,	State, Zi	p Code)				
more, MD Pages I and 2 sho ent of Health and ut: If item 27 is		Tameka Lee- Ro	<u>binson</u>	/ Wife		2205 Place of Dispo			d Drive	Distr Date	ict	Height Location - C	s, M	D 2074	7			
altimore, rmit. Pages I ar epartment of Hee pportant. If ite jury or other tr		20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Remo	val from Sta	. I .	crematory or o			·									
time L. Pag Iment rtaut:		4 Donation 5 Other Specify: Fort Lincoln 2/ 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Po									Br	entwoo	d, M	lary1an	ıd			
Baltil permit. Departm Importa		21. Signature of Funeral Service	e Licensee	· M	11085				oro Pike						1747			
Physician		23a. Part . Enter the disease, of	or complications	that caused	the death	. Do not enter	the mode	e of dying, s	such as cardiac or	rrespiratory	arrest, s	hock, or heart		Approximate I	interval			
/Medical		failure. List only one cause on each line. Between Onset and Death Death																
xaminer		Immediate Cause (Final disease a. MUITIPIE GURSTOT VVOLTIOS Due to (or as a consequence of):																
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'60, ate be	Med	IF FEMALE:		yes, outcor	me of preg	nancy					2	23d. Date of de	elivery					
687 certific ding 1	ian/	23b. Was decedent pregnant in past 12 months?	incy	Month Day Year														
Box 68760, a death certificate be the attending physiced for use as the bur	Physician/Medica	1 Yes 2 No 9 Unknown 9 Unknown																
O. In at the d by the etachec		Part II. Other significant cond	itions contribu	ting to deat	h but not r	esulting in the	e underlyir	ng cause gi	ven in Part I.			co use contribu						
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Rec The la cate h	mo												✓ Yes	2	No			
tal Frian: certifi ector,	Be	25. Was case referred to medic examiner?	Hospital:			ER/Outpatie		1/	of Death (Check									
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Div ital or urs aft	Certification:	3 Suicide 6 Could not be determined (Specify) Interstate/Express										or Town, State) 5827 Allentown Way, Clinton, MD						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying one) 2 Medical Ex	Physician: To the	ne best of m	y knowled	ige, death occ	curred at t	the time, da	te and place, and	due to the o	cause(s)	and manner a	s stated	cause(s)				
To the within To the comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number											ned (Month, Day, Year)					
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		30. Name and address of person	on who complete	cause of c	death (Iten	n 23a)												
CR 5		Theodore M. King, J				Examiner	111 F	Penn Str	eet, Baltimor	e, MD 21	201							
	tate		Parent !	32. Regi	ar's Signat	ure								<u></u>				
Regis	urali	FFR 11 4 2009			1													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh g907 9-16-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month 2009 Rosendo Ramirez 1 31 1317 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. (In vrs. last birthday) 8. Date of Birth (Month, Day) 2-5r) 5. Social Security Number 1 ☑ M 2 ☐ F Months Days Hours 85 84 228-39-7279 10-1-1 El Salvadore Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 1√ Yes 2 No Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4303 Holmhurst Way 20720 El Salvadore 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1X Yes 2 No Specify: Salvadorian White Snecify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Laborer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fedelia Ramirez Cecilio Martinez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Felicita Heureaux - daughter 4303 Holmhurst Way, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 2/7/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 20722 3401 Bladensburg Rd., Brentwood, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last crusiden Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 100 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

28a-f show

items 23a or

"natural", or

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau

Examiner must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-tran this After t after death Director: 24 hours a

Physician/Medical

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Completed

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Certification: To

Medical

State

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Ceath 1 Natural 2 Accident 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

Registrar

31. Date filed (Month, Day, Year) **FEB** 0 5 2009

29b. Signature and title of certifier

Unirusity 32. Registrar's Signature

BLVD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

29c. License number

00060

29d. Date signed (Month, Day, Year)

MD

			For Amend Item 2	5 Per me,	arylan g 888 ,	02/24/ Ce	ortme 09dh rtifica	at of H	lealth a	and M	lental Hy	giene Reg. N	009	051	09
	Physici	an	1. Decedent's Name (First, Middle, Lat	st)							2. Date of De Month	Day	2009	3. Time o	of Death
	/Medic	al	4a. Facility Name (If not institution, giv		· · -		4h City	Town or	Location of	of Death	01	40.0	ounty of Death	101	O 7 IVI
)	Examin	er		HOSPITAL			-	UIM		-		10. 0	ounty of 2000.		
	Funeral		5. Social Security Number 6. S			last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth	place (State	or Foreign
	Director		221-26-2363	ETM STIL	75	Yrs.					10/8/19	933			ID
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	or 28	Dire	10e. Street and Number					p Code					n of What Cou	ntry?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Mydical Examiner mest be notified at	Funeral Director	501 WEST FRANKLIN	· · · · · · · · · · · · · · · · · · ·	Francis (II)	0 10		.201	inneria Ori	-i=2 /C=	anifu Van or N	USA		on Indian	
	ter de	E	11. Marital Status 1 ☐ Never Married 2 🖔 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅			If Yes, sp	ecify Cuba	ın, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0- 14	Black, White,		
93	ral", or	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes	2 🔀 No	Specify:			S	pecify: WH	ETE	
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12	within ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5	5+)	FARM	DO NOT : TNG	use reured	"			AGRI	CULTUR	₹	
þ	al Hyg other	BeC	17. Father's Name (First, Middle, Last,)			.		18. Mothe	er's Name	e (First, Middle				
ylar	should be ind Mental marked o	70 E	JOHN MORGAN ROWAN	1					MAR	JORI	E LEAG	ER			
Mar	2 sho n and 'Is ma		19a. Informant's Name/Relationship (•	•					Town, State, Zi		
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mydical Examine must be refilled at once.		21. Signature of Funeral Service Lice		1 301	2	2. Name a	and Addre	ss of Facilit	ty			JNERAL 1		
<u> </u>	8 9 E 8 8		1 Auch	100xe	$\geq <$	3	70 W.	CYP:	RESS	ST.	MILLING	GTON,	MD 216		
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8760,	Examiner	lical Examiner	Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for as b. Gas Cue to for as c. Due to for as	a conseq	uerice of).	nal	blee	<u>d</u>	CERTIFIC	M./	D BY MEDICA	LEXAMINER	36	hours
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗆 Feta	al déath 3	□ Ectopic						d. Date of deli Month	ery Day	Year
	e law requires that the d has been signed by the le 2 should be detached	ρ	Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	underlying	cause giv	en in Part I				e contribute to No 3 ☐ Pro		death? Unknown
of Vital Records,	: The law re cate has bed page 2 sho	Completed									24a. War auto per 1 🗆 Yes	opsy formed	24b. Were aut prior to c death? 1 □Yes	opsy finding ompletion of 2 No	
Vita	ilcian: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth Oth		e of Deat	h (Check only	one)			
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on	Attending Physician: or death. ector: After this certification by the funeral director.	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Da	ay, Year)	Injury	М	28c. Injur Wor 1 🗆	ḱ? Yes 2□	No	250. 2000//20	,			
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	To the Hospital or Attent within 24 hours after deatt To the Funeral Directors completely filled in by the	Medical (29a. Certifying P (Check only one) Certifying P Certifying P	hysician: To the best miner: On the basis and manner s	of examina	owledge, dea ation and/or i	th occurre	ed at the ti	me, date a opinion, de	nd place ath occur	, and due to the red at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause	e(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	0	111	\	2	9c. Licens		200	21	/	signed (Month		
			Eme Marc	oun 1)		m	0969	100	/	72	26/20	フ	
	1 m		30. Name and address of person who	completed cause of	oeath (Iter	m 23a) (Type Z <i>OSO</i> , S	Print)	PITA	1 - 7	60)0	W. BA	LTIMOR	rest	BATIL	WORE 14
		ate rar	31. Date filed (Month, Day, Year)	32. Regist	ar's Signa	ature A .	for	di				-		2	1223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day RUNALDUE ee SAUNDRA February 10, 2009 1:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center La Plata Charles Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 F 215-60-6665 September 18,1952 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County Maryland Charles 1 ☐ Yes 2 No Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8553 Keech Rd. 20622 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard W. Wrzesinski Doris Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Runaldue Husband 8553 Keech Rd., Charlotte Hall, MD 20622 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 1 👿 Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens 4 Donation 5 ☐ Other (Specify) 14,2009 Waldorf, Maryland 22. Name and Address of Facility Brinsfield-EChols F.H., P.A., 21. Signature of Funeral Service Lige 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute ventricular disease or condition resulting in death) Due to (or as a consequence of) YON GRU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exactions in roust by rediffed at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, I'm Medical Eval, i'm triust be note.

Baltimore, Maryland 21215-0036

as the burial-tran and attending physician cate has been signed by the page 2 should be detached

Examine Physician/Medical þ Completed certificate Be

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

Medical

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Certification: To

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D0022102

1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

FEB 12 2009

MARY KRAMER

Dr., Charlott Hdl, MD 20622 MARKET 32. Redistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9,2009 WANDA GRACE ROHR Februan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FAHRNEY-KEEDY HOME BOONSBORO WASHINGTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days Hours 215-26-9096 Director 81 ЛИЕ 24, 1927 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Inscited Exymptor must be notified at Director 1 ☐ Yes 2 No MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 MAPLEVILLE ROAD 21713 Funeral U.S.A13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Force Black, White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ⋧ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 INSPECTOR EYE GLASS MANUFACT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I nent of Health and Mental JOHN AUGUSTA BOWERS SR. ELEANOR ELIZABETH NOKES ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If Item 27 is any injury or other trau JOSEPH R. ROHR/SPOUSE MEADOW LANE, BOONSBORO, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 1 X BurjaL 2 ☐ Cremation BROWNSVILLE HGTS. CEM 2/12/2009 4 Donation BROWNSVILLE, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Sign ture of Fu Paul M. Dean 7606 Old National Pike, Boonsboro, MD 21713 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementi OX disease or condition resulting in death) /Medical Due to (or as a consequence of): Heart Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Mellitos Physician: The law requires that the death certificate be executed and burial-tra P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖽 No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 📈 No 1 □Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ne Hospital or Attending Pon 24 hours after death.

The Funeral Director: After the futer is filled in by the funeral Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🖳 🚅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) соmpletely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 052323 2000

State

Wanda

Registrar

1126 Opal_Court, Hagerstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Khalid H. Waseem.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ROLLMAN 6:08 PM JUSEPH 2009 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL BALTMORE WASHINGTON MEDICAL GLEN BURNIE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 ☑ M 2 🗆 F 4, 83 Director 577-22-7150 Oct. 1925 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multified at once. Director 1 ☐ Yes 2 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1586 Chapman Rd. 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 yes 2 No If Yes, Give Year or Dates: 1943-46 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify:White ⋧ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Telecom 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (John Rollman Gladys Carpentier ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Harshaw / daughter 472 St. Barbara Lane Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1√Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify) Resurrection Cemetery 2/7/2009 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** ARRES HOURS /Medical Due to (or as a consequence of): Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, CARDIOMYOPATH signed by the attending physician and ibe detached for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. Ne Funeral Director: After ti 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. :ompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

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J

ANDREW MCGLONE MD 31. Date filed (Month, Day, Year) FEB 02 2009 Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002 MEDICAL PARICUAY # 670 ANNAPOLIS MD parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** 2009 Helen W. Robinson 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Massachussetts 065-28-4607 86 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r Pages 1 and 2 should be filed within 72 hours after death with 7110 Minstrel Way 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1₭ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced 'natural" the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel Worthen Mary Colby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Lamich / Daughter 9384 Sewall Ave., Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XICremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) Ardent Cremation 2-5-2009 Hanover, MD 21. Signature of 22. Name and Address of Facility Harry H. Witzke's Family FH, INC. al ervice Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ALTHEMER . ZVEXES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy perform or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. FEB. 5, 2009 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State Registrar

parke

PARKWAY #301, COLUMBIA, MP 21045

SNOWDEN BYER

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 🗸 📗 🗎 🦞 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 28, 2009 12:02A M Anthony Quinn Sligh January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7603 Eastern Ave #103 Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 SC 7. Age (In yrs. last birthday) 8. Date of Birth <u>Funeral</u> Days Hours 124M 2□F Director 251-04-9333 12/27/1955 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Exercical must be notified as ADEs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 □ No Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7603 Eastern Ave #103 20912 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 174-179 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced B1ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry George Washington Elementary/Secondary (0-12) College (1-4or 5+) Campus Police 2yrs University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk 2 Nona Sligh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1424 Meridian Pl, NW Washington, DC 20010 Nona Boozer/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2/5/2009 Brentwood, Maryland Ft. Lincoln Cemetery 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street NW Washington, DC 23a. Page Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Ventricular Arrhythmia</u> /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to initialistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a norisequence of) physicien and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery ξ 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sete has been significant page 2 should be Diabetes Mellitus Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 📈 6 Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of oxamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, 56147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 Carroll Avenue Nasreen Kango Takoma Park, Maryland 20912

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FER 0 4 2009

			1- State of Maryland / De Registrar	partment of He ertificate of De			ene g. No. 2009	05115
r			Hegistrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		Cecelia Serphina Spence		J	Month anuary	26, 2009	8:20 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo			4c. County of Deal	
			Prince George's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cheverly If Under 1 Year I		B. Date of Birth	9 Rirl	hplace (State or Foreign
	Funeral Director		100-50-7866 1 M 2 X F 61 Yrs	Months Days	Hours Min.	(Month, Day, Y	Year) Co	untry) Andrew, Jamaica
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			1	10d. Inside City Limits
	faryla shov	or	Maryland Prince George's Lanham	Location				1⊠Yes 2 No
	the N 28a-1 notifi	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	untry?
	th with 23a or 1st be		8810 Cipriano Court	2070	6		USA	
	tems ter mu	Funeral	Armed Forces?	Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spec , Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
0000	rs afte I', or i xamir	by F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify: B.	lack
5	12 hou natura ical E		15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	ion ring most of working	7 16	6b. Kind of Business	Industry
Ž	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done dur e. DO NOT use retired) eacher	ing most of working	,	Educati	ion
V	e filed wall Hygie other t		17. Father's Name (First, Middle, Last)		8. Mother's Name (First, Middle, Ma		
and	be of o	To Be	Richmond Walter Nelson		Florence	Pearlin	e Murphy	
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≥ ຜົ	s 1 and if Health item 27 other tr			O Cipriano			D 20705 Oc. Location - City or	Town State
101	Pages nent of fi int: If ite		TABURAL 2 Cremation 3 Chemoval from State	sposition (Name of crematory or other place) nal Memorial 1	'		aurel, Mar	
банитог	그 든 뜬 등		21. Signature of Funeral Service Licensee	22. Name and Address				imore Avenue
Ď	permi Depa Impo any ir once.		D 1 A	Gasch's Fun		P.A.	Hyattsvil.	Le, MD 20781
			23a. Part . Enter the di ease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying,	such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of	17,1150	riensio	n		
we die	Examiner		End Corn	Renal	riensio dise	ase		
	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inilitated events c.					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of):					
8/00,	death certificate be executed e attending physician and d for use as the burial-transit	dical E	d					
0	rtificat ng phy as the	Nedio	IF FOUND S					
o o	leath certific attending p I for use as	ian/N		3 ☐ Ectopic pregnancy			23d. Date of de	ivery Day Year
<u>.</u>	the de	Physician/Me	1 Yes 4 No 9 Unknown	5 ☐ Other (specify)	<u> </u>			,
, Z	sician: The law requires that the decertificate has been signed by the rector, page 2 should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Hecords	equire en sig buld b					1 - Yes	2 □ No 3 □ Pi	robably 41 Unknown
ပို့	e law r nas be e 2 sh	Completed				24a. Was an autopsy	prior to	topsy findings available completion of cause of
_	n: The licate har, page						No 1 □ Yes	2□ No
VICAL	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpa	Other	26. Place of Death		nce 6 □Other (Spe	cife)
DIVISION OF	ding Phys h. After this (funeral dir	n: To	27. Manne of Death 28a. Date of Injury (Month, Day Year) Injury Injury	e of 28c. Injury a		3d. Describe how		ony)
SIO	tendir eath. tor: Af the fu	catio	2 Accident investigation	M 1 ☐ Ye	es 2 No			
<u> </u>	al or Attending F s after death. Il Director: After d in by the funeri	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28	City or Town,	eet and Number or R State)	ural Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, d					
	the Ho lin 24 I the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.					
	Nation 10	2	29b. Signature and title of certifier M.D. Sarrarah M.D.	29c. License r	number 4 (04)	296	d. Date signed (Mont	h, Day, Year) うしり
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print)		2	d. Date signed (Mont \(\frac{1}{2}\lambda \int \frac{1}{2}\lambda \int \frac\	70000
R	2		Mohammad Sarifuruzi 5810	Valence	r lane) <u>LOCIC</u>	.oni, (11)	20834-
	Sta Registi		FEB 0 3 2009 Consult Signature S. Registrar's Signature S. FEB 0 3 2009	•				

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			for State Registrar	State of Marylar	nd / Depa <i>Cel</i>	artment of H <i>rtificate of</i>	lealth and I <i>Death</i>	Mental Hyg	iene _{g. No.} 200	9 05116
ı	Physici		Decedent's Name (First, Middle, La DEBORAH	SHAW				2. Date of Death Month JANUARY		3. Time of Death ar 7:22 A M
*	/Medic Examir		4a. Facility Name (If not institution, given	H - ·		_	r Location of Death		4c. County of D	Death
	Funeral Director		5/9-/4-4901	Sex 7. Age (In yrs. 1 ☐ M 2 ☒ F 55	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 2 I	9.53 V	Birthplace (State or Foreign Country) VASHINGTON, DC
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MD PRINCE		ty, Town or Lo					10d. Inside City Limits 1 ☐Yes 2 ☐ No
	th with the 23a or 28a	al Director	10e. Street and Number 4028 23RD PARKW			10f. Zip Code 2074	48	10	og. Citizen of What	Country?
036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, tre Medicul Exyroider must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		omerican Indian, /hite, etc. BLACK
Maryland 21215-0036	vithin 72 hou ene. than "nature e Medicul E	Completed	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	king	16b. Kind of Busine	•
land 2	be od o	To Be Co	12TH 17. Father's Name (First, Middle, Last GEORGE DYSON)		FOOD 51	18. Mother's Nam	ne (First, Middle, M		SKNITEN I
, Mary	r 2 mg		19a. Informant's Name/Relationship (GHTER	4028	23RD PAI		TEMPLE	HÍLLS, MAI	RYLAND 20748
altimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	HAF	RMONY C	sition (Name of matory or other plac CEMETERY	2/4/	2009 L	20c. Location - City ANDOVER, I	
Ва	permi Depa Impo any ir		21. Signature of Fun val Sarvice Clos	2.			OOVER ROA	D LANDOV	ER,MARYLA	AND 20785
	Physician /Medical		23a. Part 1. Enter the disease, or ear shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	prications that caused the deat one cause on each line. PANCREAS Due to (or es a conseq	CANCER	·	ng, such as cardiac	or respiratory arre	est,	Approximate interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	bDue to (or as a conseq	uence of):					
28/60,	ficate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
O	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	aldeath 3 □	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у		23d. Date of Month	delivery Day Year
ecords, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 1 Unknown
ĭ	The la ate has page 2	Completed						24a. Was an autopsy perform 1 □Yes 2.	prior	autopsy findings available to completion of cause of n? Yes 2 🕅 No
VITAI	Physician: this certificanal director, partition	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	LEDIO ALLE	Oth	or:	h (Check only one		
VISION OT	nding Phy ath. r: After this e funeral d	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe how	nce 6 Other (5	specify)
DIVIS	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check only 2 Medical Exar	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deatl ation and/or in	vestigation, in my o	ppinion, death occur	rred at the time, da	te and place, and	due to the cause(s)
	vitl To	2	29b. Signature and title of certifier	Chinota		29c. Licens			d. Date signed (Mo	
			30. Name and address of person who						AND 2070	
	Sta	e	MARTIN WELTZ M. 31. Date filed (Month, Day, Year)	D. 7350 VAN I	TUSEN S	TKEET #	JZU LAURE	LL, MAKIL	AND 20/0	,
	Registr		FEB 0 3 2009	32. Registrar's Signa	gare					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Physician 11:40 am Juan Soto, Jr. February 01 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laure1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Davs Hours 1⊠M 2□ F 85 Director July 04, 1923 Puerto Rico 581-68-9662 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natura!" any injury or other traumatic exercises. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County 1 ☐Yes 2 K No Director Prince George's Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 3158 Gracefield Road, #FC220 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No 1 ☐ Never Married 2 🕅 Married If Yes, Give Year or Dates:1943-1963 1⊠Yes 2□No Specify: Puerto Rican Specify þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CPA 4 Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juan Soto Carmen Rodriguez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3158 Gracefield Road, #FC220, Silver Spring, Maryland 20904 Rita D. Soto - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/10/2009 Brentwood, Maryland Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Myclin . Wobert Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Chronic Myelogenous Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events of Vital Records, P.O. Box 68760 resulting in death) Last Due to (or as a consequence of): physician at the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 TNo 9 ☐ Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Division 1 X Natural 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 2, 2009 D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hilds Ann Smoot 30, 2009 January 6:30A. M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 25, 1928 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 577-32-4813 80 Director Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating the retiting at Director Maryland Howard Laurel 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8310 Sand Cherry Lane 20723 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9-12) College (1-4or 5+) Meat Cutter Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Voigt Lena Gartner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Millard E. Voigt, Jr. -Nephew 8310 Sand Cherry Lane Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 2/6/2009 Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA
4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Service Licenses only 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** Uro Sepsis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 □Yes 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760. signed by the at Division of Vital Records, should be page 2 s certificate has

death certificate be executed attending physician and for use as the burial-tra or Attending Physician: nours after death.

neral Director: After this or
filled in by the funeral dire Hospital

show

Baltimore, Maryland 21215-0036

within 24 hours a ္ဝ

> State Registrar

Medical

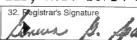
31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

04 FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Rukmini M. Konatalapalli, M.D. 10724 Little Patuxent Parkway, #200 Columbia, Md.21044

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D66339

29d. Date signed (Month, Day, Year)

February 2, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 3:45P M 29 2009 Sides January Josie Irene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛣 F March 20, Virginia Director 223-24-7277 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Silver Spring 1 ☐ Yes 2 X No Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 20902 United States of America 2010 Glenhaven Place Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Caucasian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millard Filmore Sanford Edna Lee Rowe ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2010 Glenhaven Place; Silver Spring, MD 20902 Harold N. Sides - Husband Department of Health Important: If item 27 any injury or other the 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft Lincoln Crematory 02/04/2009 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville MD 20852 23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Stroke **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 I Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown History of Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy performed 1 ☐ Yes 2√No 1 ☐ Yes 2 ☑ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2√2 No 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, DO 1500 Forest Glen Road; Silver Spring Md 20910 Registrar's Signature 31. Date filed (Mon State 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3Ö', 07:00 aM January 2009 Magdalene Shupe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Assisted Living Silver Spring 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year) June 04, 19 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Hours 1 ☐ M 2 🖫 F Months Days 1915 93 189-10-5243 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at 1 √2 Yes 2 □ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 2305 Falling Creek Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify ģ Caucasian 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Furrier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelmina Elizabeth Ludwig Lawrence Schorr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1926 5th Court ; Vero Beach , FL 32960 John F. Shupe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Lincoln Crematory 02/06/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike, Rockville, MD 20852 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enjer the disease or complications that caused the shock, of heart failure. List only one cause on each line. for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician 1 hour disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** years General Debility Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of sician and burial-transit Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical as use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown atten for us 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a P.0. I ☐Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown spital or Attending Physician: The law require ours after death.

eral Director: After this certificate has been si filled in by the tuneral director, page 2 should I Completed 24b. Were autopsy findings evailable prior to completion of cause of deeth?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ${}_4\square$ Nursing Home ${}_5\square$ Residence ${}_6\cancel{\Box}$ Other (Specify Assisted Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Living 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D17874 Jan. 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3717 38th Avenue; Cottage City, MD 20722 S.M. Nayar. M.D. 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BEATRICE FLORENCE STRETTON 2009 FEBRUA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kent TOWY If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11/25/1906 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2**X** F 067-32-7723 Director 102 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Madical Examination and the modified 1 X Yes 2 ☐ No CHESTERTOWN Director MD KENT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21620 9784 SWAN CT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADVERTISING RECEPTIONIST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ CARL ARNHOLT ANNA VOLK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9784 SWAN CT. CHESTERTOWN, MD 21620 t of Health NANCY BURNS/DAUGHTER other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Important: If any Injury or once. CHESAPEAKE CREMATION 2/3/2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Kick SA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): FIBRILLATION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burlat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 : autopsy perform 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Paffer death. 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and little o FEBRUARY 1, 2009 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESTER RIVER HOSPITAL CENTER -BROWN ST. CHESTERTOWN, MD RUAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		For State	State of Ma	-	epartment of Certificate			ental Hy	giene Reg. No. 20	ng	05122
***		Registrar 1. Decedent's Name (First, Middle,	Last)			oi Deaii	<i>'</i>	2. Date of Dea			3. Time of Death
Physicia /Medic		GARY	L. S	TOLL				Month	23	Year 09	203U M
Examin		4a. Facility Name (If not institution, 1976) 762 Benfield B				vn, or Location erna Pa			4c. County Anne		del
Funeral		5. Social Security Number 6	5. Sex / 7. Ag	ge (In yrs. last birt	hday) If Under 1 Y		r 24 Hrs.	8. Date of Birt (Month, Da	h I		lace (State or Foreign
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the Ma	Director	MD Anne	HUIGEL	pever	10f. Zip Co	de			10g. Citizen of V	Vhat Count	1 ☐ Yes 2 XNo try?
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permit. Pages 1 and 2 s Department of Health ar Important: If them 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3		cemeter	Disposition (Name of the Crematory or other Crematory	r place)	Jan. ^D	• 1	20c. Location -	•	
antii. P partme portan y Injuri	1	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li	_			•		- 1		· ·	neral Home
8 3 E 8 8		Jacob Ch	The	<i>T</i>	1 495 Gov	. Ritcr	пе ни	v, sev	erna Par	k, MI	21146 Approximate
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To the Hospital or Attending Physician: The law requires that the death certificate hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one) Certifying Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination an	, death occurred at d/or investigation, in	the time, date my opinion, d	and place, eath occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as st and due to	lated. the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	V _1		29c. L	icense number	~	,	29d. Date signe	d (Month, I	Day, Year)
	1	you way c	to girta	W) VI	438	A /	Jonus	rya	6,2009
ONE		30. Name and address of person w	LENTA IM	1445	DEFENSE	Has	HWA	y A Not	APOLIS 1	402	140/
Sta Registr		31. Date filed (Month, Day, Year) JAN 3) 2009 32. Regist	rar's Signature	parked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Stan LOUIS 0440M $\mathcal{Q}\mathcal{S}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mediter ma 10 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 8 9. Birthplace (State or Foreign Min. Months Days Hours Maryland 1**∑** M 2□ F 1952 56 Yrs 214-54-8893 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 Oakdale Rd. 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2**X**No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Aviation Elementary/Secondary (0-12) College (1-4or 5+) 12th n Maintenance Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Stansbury Arie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 Oakdale Rd. Glen Burnie, Md. Faye R. Stansbury(Wife) 21060 20b. Hilaca of Dis dane sylame of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 2-2-09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winname Receipt of Good Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Tarry 15, Ages Moor83 821 West St. Annapolis, 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIO COCCUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Minpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or

3altimore, Maryland 21215-0036

Physician/Medical Examiner the burial-tran use as t for Completed by Be

Hospital or Attending Physiclan: The law requires that the death certificate be executed physician ed by the a detached f ate has been signed I page 2 should be det certificate funeral director, After this n 24 hours after death.

le Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

the State Registrar

Medical Certification: To filled in by completely within 24

31. Date filed (Month, Day,

29b. Signature and title of certifler

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

2001

32. Registrar's Signature

part ORIGINAL

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Jane	be deve	To Be	Ronald D.									God		ŕ		
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Astremt Knawn ad Baltimore, Maryland	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral S	ervice Licensee				WnName Re 821 We						-		
<u>~</u>		(En s)	23a, Pa 11. Enter the dise.	ase, or complications	e that caused	the death						-		riu. Zi	Approx	imate
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∑ ✓	hysik this c	မ	1 Yes 2 No	Hospita	1 Lu Inpati			tient 3 DOA		4 🗀 Nurs				6 ☐ Other (S	pecify)	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.		(Check only 2 M	ertifying Physician edical Examiner: 0												use(s)
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	Land	7	30. Name and address of	person who complete	ed cause of	death (Iten	n 23a) (Tyr	pe, Print)	00	[4 1			eu l	eny "	.0770	
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Division of Vital Records, P.	To the Hospital or Attending Physician: The law requires that t	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by
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	•	For State Registrar				,		ertificat					Reg. No	-	09	0512	26
Division		1. Decedent's Name	e (First, Midd	e, Last)								2. Date of D	Death	N/ -	Year	3. Time of Dea	
Physicia /Medic			Willi	am Le	e SPF	RANKL	E					Feb	ruar	4	200	1.50.	M
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Mary Fresh	tor	Maryland	Washi	ngton		На	agerst	own								1 X Yes 2 □]No
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tems er ms	nue	11. Marital Status		Arı	s Decedent ned Forces?	?	S. 13	. Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	No-		e - Amer k, White	rican Indian, e, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination at coffined at once.	þ	1 Never Marr	_	If Y	¶Yes 2 ☐ es, Give ar or Dates:	195		1 □ Yes 2	X No	Specify:				Specify	/: W	hite	
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Depar Impo any Ir			Fred &	Vestel	1			415 Ea	st W	ilson	B1v					aryland 2	1740
Physician /Medical cian and purial-transit	Examiner	Immediate Cause disease or condition resulting in death) Sequentially list coniform in any, leading to improve the cause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on on on on on on on on on on on on on	S c	tophle	s a consequence a consequence	uence of): uence of):	fre	M	omei) -					Approximate Interval Between Onset and Death	h
To the Hospital or Attending Physician: The law requires that the death certificate be erwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medical E	IF FEMALE: 23b. Was deceden in the past 12 1 □Yes 2 [months?	23c. If y	res, outcome	e of pregna 2 ☐ Feta	ancy	B ☐ Ectopic p		,				23d. Dat	te of deli	ivery Day Year	
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quires than signed and be de	ک	Part II. Other signi	ficant conditi	ons contributi	ng to death I	but not resi	ulting in the	underlying c	ause give	en in Part I.						the cause of death	.
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s iciar certif	Be	25. Was case referexaminer?	A	Hospita	l: 1				Othe	DE:		n (Check only					
Physic this aral di	5	1 Yes 2 5 27. Manner of Deat			n Date of Inj	jury	ER/Outpat 28b. Time	ent 3 DC	/A	4 LI Nui		me 5 Re				cify)	
Attending or death. ector: Afte by the fune	1 Yes 2 5RNo																
ospital or hours aft neral Dir y filled in	building, etc. (Specify) City or Town, State) 29a. Certifier (Check only) City or Town, State) 29a. Certifier (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)																
o the Hc vithin 24 o the Fu ompletel	Medical	(Check only one) 29b. Signature and		aı	n the basis nd manner s	ot examina tated.	ation and/or					red at the tim				to the cause(s) h, Day, Year)	
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1 - For State Registra Physiciar

Please T	ype or Print in Black Indelible Ink. Ensure Al	Il Copies Are Legible.	
	State of Maryland / Department of Health and N Certificate of Death	Mental Hygiene 0 0 9	05127
ar	Octamodito of Doday		0 Time (D)
s Name (First, Middle, Last)		2. Date of Death Month Day Year	Time of Death
Austin Sisk		January 27, 2009	9:23 P M

/Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at another.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name					_				Date of De Month		ay	Year	3. Time o	f Death
an	John Aus	tin Sisk								Januar	-		009	9:23	3 P M
al er	4a. Facility Name (II	f not institution, g	ive street and num	ber)		4b. City,	Town, or	r Location	of Death		4	c. County	of Death		
•	Calvert N	Memorial	Hospita.	1		Pr	ince	Fred	eric	k		Ca	1vert		
	5. Social Security N		Sex	7. Age (In yrs. I	last birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth av Yea	r)	9. Birth	place (State ntry)	or Foreign
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	Usual Residence of			140.00	_									10-1 Incide C	State I See San
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Be Completed by Funeral Director	20 Promi	se Lane					736						State		
une	11. Marital Status	**	12. Was Deced	ces?	S. 13.	Was Dece If Yes, spe	dent of H	lispanic Or an, Mexicai	igin? (Spen, Puerto	ecify Yes or No Rican, etc.))-		ce - Ameri ck, White,	can Indian, etc.	
Ϋ́	1 ☐ Never Marri	ed 2 Married	1 ∐Yes 2 If Yes, Give Year or Da	e		1 ☐ Yes	2 💢 No	Specify:				Specif	fy:	White	
edt	3 Ll Widowed	15. Decedent's		ies.	16a. Dece	dent's Usu	ial Occup	ation			16b.	Kind of B	usiness/In		
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e C	17. Father's Name (First, Middle, La			2 642 66			18. Moth	er's Name	(First, Middle	, Maide	n Surnar	ne)		
To B	Shirley h	Mason Si	.sk					Corn	elia	Perces	sfry				
-	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Address	s (Street	and Numb	er or Rura	al Route Numb	er, City	or Town	, State, Zi	p Code)	
	Laura J.	Sisk/Wi	.fe		20 P	romis	e La	ne, O	wing	s, Mary	lan	d 20	736		
	20a. Method of Disp			20b. P	lace of Dispo emetery, crei	sition (Na	me of	ce) ;		Date	20c.	Location	- City or To	own, State	
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	21. Signature of Fu									rge P.					
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	23a Part 1. Enter the shock, or hea	he disease, or co	mplications that ca	used the death	n. Do not on	tes the mod	de of dyir	ng, such as	cardiac	or respiratory a	arrest,			Approxima interval Be	te
	Immediate Cause (Final	y one cause on ea	ch line.	1 lu	mar	Tim							Onset and	Death
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cian/Medical Examiner		•	d. 174	well	nen								-V	VILY	J
Me	IF FEMALE:														
ian	23b. Was decedent in the past 12			irth 2 🗆 Fetal	death 3	Ectopic		y .					ate of deliv onth		Year
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d by										1 🗆	Yes	2 🗌 No	3 Pro	bably 4	Unknown
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ifica	3 ☐ Suicide	6 Could not	be 28e. Place	of Injury - At ho g, etc. (Specify	ome, farm, st	reet, factor	y, office			28f. Location			ber or Rur	al Route Nur	nber,
ert	4 Homicide		bulldin	g, etc. (<i>Specii</i>)	у)					City or To	WII, Sta	ite)			
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Medical Certification: To	one)		aminer: On the ba and mann		Con and/or II				au i Occur	Towar and unite		,			
Σ	29b. Signature and	title of certifier	1	1.1		29	c. Licens	e number	7-	1	29d. E	are signe	ed (Month,	Day, Year)	
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	30. Name and addr		. /								7	7			
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Frederick Michael Smith 8:37 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 76 Crest Haven Dr. Ocean Pines Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year 9/17/1930 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min 78 PA 162-26-4508 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov s 23a or 28a-f show Director 1 ☐ Yes 2 X No MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Crest Haven Dr. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □**X**'es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or items other traumatic event, the Medical Experiments 11. Marital Status 14. Race - American Indian 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify Specify: white þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Printer Compositor US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Herbert Smith Gertrude Flannagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Janice Smith / wife 76 Crest Haven Dr., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atlantic Crematory 2/10/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastot.c Adeno corcinoma of Lun disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate 1 □Yes 2 XNo 1 ☐ Yes 2 🗆 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NO 030690 Feb. 3. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MART 100 E. Carroll St., 5-1:5500, MD 3.80, IN 31. Date filed (Month, Day, 32. Registrar's Signature Year) State eneur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day Year SMITH \mathbf{P}^{M} **THERESA** ROSE 2009 FEB. 4:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34514 PITTS AVENUE WICOMICO PITTSVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 222-24-3723 FEB. Director 18, 1941 DELAWARE 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 □ No MARYLAND WICOMICO PITTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34514 PITTS AVENUE Funeral 21850 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene.

m 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) PAYROLL ACCOUNTANT POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY AGNES **FRANCKS** DONAHUE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health an Important: If item 27 is any Injury or other trau 34514 PITTS AVE., PITTSVILLE, GARY J. SMITH/HUSBAND MARYLAND 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/09 4 □ Donation 5 □ Other (Specify) DALE CEMETERY WHALEYVILLE, MARYLAND of In all Service Lic 22. Name and Address of Facility 21. Signatus HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed? Yes 2 No certificate 1 □ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) this ပ 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: the Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) H50497 2/3/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 21801 Salismy D.0. 100 E Canon St. Chris Snyder DWE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 4 Registrar

			State of Maryland / Department of Certificate	of Heal	Ith and N	nental H		09	05130
			Decedent's Name (First, Middle, Last)	0. 000	-	2. Date of E	Reg. No.		3. Time of Death
J. J.	Physicia /Medic		Pocohantas Winifred Scott			Month	Dey	Year	
	Examin		4a Fecility Nema (If not institution, give street end number)	4b. Ci	ty, Town, or L	Janua:		2009 Ity of Death	8:13 AM
			Holy Cross Hospital	Si	lver S	orina		jamery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1	Year If U	Inder 24 Hrs.	8. Date of E (Month, L	Birth		lace (Stata or Foraign
ja	Director		377 30 1030 Hs.	Jays Ho	ours Min.	July	<i>)ay, Yaar)</i> 14. 1925	Wash	ington, DC
	B	-	Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location						
	Marylar f show	5	MD Prince George's District Hei	iahta				10	0d. Inside City Limits Yall Yes 2 □ No
	the Maryla 28a-f shor	Director	10e. Street end Number 10f. Zip Co				10 0:::		
	를 즐겁	٥	101.20	0747			10g. Citizan o USA	What Count	ry?
	daati	Funeral	11. Mantel Status 12. Was Decedent Ever in U.S. 13. Was Decedent	t of Hispeni	ic Origin? (Sp	ecify Yes or N		ace - America	an Indian
0	after or he		Armed Forces? If Yes, specify 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No			Rican, atc.)	Bi	ack, Whita, a	
02	ours.	<u>\$</u>	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	No Spe	ecify:		Spec	ity: Bla	ick
Maryland 21215-0020	n 72 hours "naturel",	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4075+) 16a. Decedent's Usual O (Giva kind of work diffe. DO NOT use re	occupation	most of work	ina	16b. Kind of	Business/Ind	ustry
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2	should and Men marke	ို	Taylor Hansborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (St				ıry Paul		
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=	permit. F Departme Importan any injur pnce.	1	Chicoapeane Crai	natory	/ !				
B	permit. Departrimports any inju			ouress or F	aciiiyPric	igen Fu	neral S	ervice	PA
	-	-	Juliana L. Hulger 9908 Sas					e, MD	20721
	Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the defin. Do not anter tha mode of shock, or haart failura. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non-Hodgkins Lymph Due to (or as e consequence of):						Intarval Batween Onset and Death
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Box 687	nat the daath cardificeta d by tha ettanding phys leteched for usa es tha		that initieted evants Due to (or as a consequence of): d						
-		5 F	eart II. Other significant conditions contributing to death but not resulting in the underlying causa	a given in P	Part I.	23b. Did	tobacco use co	entribute to t	he cause of death?
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Records,	- 00	ויייייייייייייייייייייייייייייייייייייי				24a. Wes	an autopsy ormed?	aveila	e autopsy findings abla prior to plation of cause eath?
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Division	its or Attending P is after death. Is Director: After t led in by the funare Certification.	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Naturel 5 Pending (Month, Dey Year) Injury	Injury at Work?		8d. Dascribe	how injury occur	rad	
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Ö	after after Dire		4 Homicide datermined 28a. Place of Injury - At home, farm, straet, factory, offin building, atc. (Spacify)	ice	2	City or To	Straet end Numl wn, State)	er or Hurel F	loute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this carific complataly filled in by the funaral director, Medical Certification: To Be 6	2	9a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the and manner stated.	e time, date ny opinion, i	and place, as death occurre	nd due to the d at the time,	cause(s) and maded	anner as state and due to th	ed. ne cause(s)
	To the To the comp		9b. Signature and title of certifier 29c. Lice	ense numb	er		29d. Date signe	d (Month, Da	ıy, Year)
		2	D. Name end addrass of person who complated ceuse of drath (Item 23a) (Tyre, Print)	2261			Februa		
		1		i 1	Contin	- RAT-	2007.0		
	State	3	Date filed (Month, Day, Year) 32. Registrar's Signatura	TTVEL	spring	J, MD	20910		
	Registrar		FEB 1 9 2009 pour fl. factor			-			

D)L DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:45 P M January 22 2009 **Physician** Kyaw Than /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Bethesda Health Rehab and Center 8. Date of Birth (Month Day, Year) 7/15/1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Days Hours Months 1, M 2 □ F 80 Burma 577-70-2904 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or human and item in the annual of which traumatic event, in "Marical Exercition", and the traumatic event, in "Marical Exercition", and an annual in a second and a second a second and cond and a second and a second and a second and a second c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County DC Washington Y Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20005 Rangoon 1111 Massachusetts Ave NW #207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: ASIAN 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Burmese Embassy Elementary/Secondary (0-12) College (1-4or 5+) Diplomat 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown Unknown Unknown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 1625 Massachusetts Ave NW Washington, DC 20036 Evangeline Covington 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Demoval from State Riverdale Crematory 1-26-2009 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John T Rhines Funeral Home LLC . Name and Address of Facility 21. Signature of Funeral Service Livensee Juan Smith 3005 12th St NE Washington, DC 20017 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failurg. e, or complications that caused the List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final, **Physician** END disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and C. Due to (or as a consequence of) burial-P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specity) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐

√o 24a. Was an autopsy performed? Yes 2 2 No The 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Rursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐EÑo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospitai 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1123109 Zew, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Rocky, 16, M1) 20850 Center Dr 31. Date filed (Month, Day, Year) State FER 0 2 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	tificate of De	ath	R	eg. No. 200	9 0513
Physicia Iedical Examir		1. Decedent's Name (First, Middle,L	,			2. Date of Dea Month February		3. Time of Death 1210 hrs
		Donald Thom 4a. Facility Name (if not institution, g		4b. C	ity, Town, or Location of		4c. County of Death	
,		3022 Brinkley Road P-2			emple Hills		Prince George	
Funeral Director			Sex 7. Age (In yrs. la	М	Under 1 Year If Under onths Days Hours	Min.	th(MM/DD/YYYY) 9. Bir Foreig	ın
	1	578-64-3893 Tourish State Usual Residence of Decedent	F M 2 F 62	Yrs.		05-05	-1946 ^{co}	wash.,Do
, any		10a. State 10b. County	10c. City,	Town or Location			1	10d. Inside City Limits
Maryland 28a-f show d at once.	ē	Maryland Prince	George's	Temple			0- 0'' (10' 0	1 X Yes 2 No
th the Maryland 23a or 28a-f she notified at once	Director	3022 Brinkley R	d Ant T2	101	. Zip Code 20748	1	0g. Citizen of What Coul USA	ntry?
with the ns 23a		11. Marital Status	12. Was Decedent Ever in U.S		cedent of Hispanic Origi		- 14. Race - Ameri	can Indian, Black,
or iten	Funeral	1 Never Married 2 Marri	1 ¥ Yes 2 No		pecify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	,
ural",	<u>a</u>	3 Widowed 4 ★ Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		2 No specify:	ind of work done	Specify: B1a	
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most o	f working life. DO NOT u		2 22 2	20 %
5-0036 iled within 72 Hygiene I other than '	du	12th		US Mail	Carrier		US Post Of	fice
	Be Co	17. Father's Name (First, Middle, La	st)			Name (First, Middle, I Ethel Thoma	,	
2121 ould be fi d Mental s markec		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Add	ress (Street and Numb	per or Rural Route Nur	mber, City or Town, State	, Zip Code)
- TO a a l		Carmelita M. Wal		4644 Br	omley Ave.	Suitland,	MD 20746	Town State
Baltimore, permit. Pages Lan Pepartment of Hee mportant: If ites	- 1	1 Burial 2 *Cremation	Removal from State	rematory or other p	ace)			
E & 0 E = (4 Donation 5 Other Spec 21. Signature of Funeral Service Lig	fy: Rive	erdale Pk	Crematory and Address of Facility	02-10-2009	Riverdale	, MD
Balti permit Departm Imports injury		Mary E. Hedge	man M013			111 PA Ave	. Suitland,	MD 20746
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		Do not enter the me	ode of dying, such as ca	rd : or espiratory arr	est, chock, or heart	Approximate Interval Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerot: Due to (or as a consequence of		vascular di	isease		Death
A		Sequentially list conditions,	b.	<i>,</i> .				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)):				
ed sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)):				
760, icate be executed physician and the burial - transit		XUNPENDED	d	perME, g8	89 3/13/09	TT		
760, icate be physicia the buria	Medical	IF FEMALE:	23c. If yes, outcome of pregn				23d. Date of deliver	<u> </u>
30x 687 death certific e attending p		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Fetal de		pregnancy	Month I	Day Year
Box le death co	Physician	1 Yes 2 No 9 Unkno		5 Other	(Specify)		1	
P.O.	by Pi	Part II. Other significant condition	s contributing to death but not re	sulting in the under	lying cause given in Par		obacco use contribute to	
ords, P.C. w requires that s been signed is	ted							itopsy findings available
COFC	Completed	· ———				autor perfo	osy prior to or ormed? death?	completion of cause of
tal Rec	e Co	25. Was case referred to medical	1		26.Place of Death (1 ✓ Yes	2 No 1 Y	es 2 No
of Vital Records, ig Physician: The law requirement. The the requirement the thick the second of the control of the second of the control of	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	- IOthor		Residence 6 V Othe	r: Scene
n of ding Ph	ü	27. Manner of Death 1 X Natural 5 Pending	(Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	
Division to a stending or Attending s after death.	Cati	2 Accident Investig	ation 28e Place of Injury - At ho	me farm street fa	1 Yes 2		Street and Number or Ru	ural Route Number City
Divis pital or At ours after d eral Direc	Certification:	3 Suicide 6 Could n 4 Homicide	ot be		story; onto building; oto	or Town, S		,
Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	(British of the	ician: To the best of my knowledg					
₩	Me	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Mayoria Op	e Uhrele		O.C.M.E.		February 7, 2009)
R1		30. Name and address of person who Margarita Korell MD.	o completed cause of death (Item : Assistant Medical Examine	,	Street, Baltimore,	MD 21201		
St		31. Date filed (Month, Day Year) FEB 1 0 2009	32. Registrant Signatu	and				
Regist	LGI.	FED TO COOS	Marie La Marie Mar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Merete Toft February 1, 2009 8:06 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🕅 F 65 July 8, 1943 Denmark Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Denmark Copenhagen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norre Sogade 19, 2. K1370 Denmark Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3 M Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruno Dinesen Ellen Trolle-Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soren Toft Kloverbakken 35, Virum 2830 Denmark (Son) 20c. Location - City or Town, State Gentofte 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 Cremation 3 Removal from State 2/10/09 4 ☐ Donation 5 ☐ Other (Specify) Helleruplund Cem. Copenhagen Denmark 22. Name and Address of Facility
Bergen Funeral Service 21. Signat re of Fureral Service Licens e inn 232 Kipp Ave., Hasbrouck Heights, NJ 07604 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracranial Bleeding Due to (or as a consequence of) Hemorrhagic Stroke Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 No

/Medical Examiner s been signed by the attending physician and should be detached for use as the burial-trans Division of Vital Records, P.O. Box 68760,

Examiner page 2 After this certificate director, funeral .cal or Att.

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Physician

/Medical

N/A

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Director

28a-f show

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Funeral

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experient Turk De notified at

hours after

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d 2 should be filed within the and Mental Hygiene.
7 is marked other than "

permit. Pages 1 and 2.
Department of Health an.
Important: If then 27 is m.
any Injury or other

Physician

Baltimore, Maryland 21215-0036

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📉 No 9 Unknown Completed by Be 25. Was case referred to medical 1X Yes 2 □ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 X Natural 5 Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only

26. Place of Death (Check only one)

February 4, 2009

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sujoy G. Tagore, MD

6430 Rockledge Dr., Bethesda, MD 20817

State Registrar 31. Date filed (Month, Day, Year) FEB 0 5 2009

To the Hospital within 24 hours a To the Funeral L

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician a M Thomas 27, 2009 Annie 5:15 Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hyattsville St. Thomas More Nursing Center Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 16, 1940 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, 6. Sex **Funeral** 1 □ M 2 🕌 F Months Florida 68 126-30-6392 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show aţ Yes 2 No notified Hyattsville Director Prince Georges Md. 10f. Zip Code 20783 10g. Citizen of What Country? 10e. Street and Number U. S. A. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 1801 Metzerott Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☒ No Maryland 21215-0036 þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 College (1-4or 5+) Navy Dept. Elementary/Secondary (0-12) Secretary 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta' Important; If Item 27 is marked on any injury or other traumatic ev Lizzie Jackson Beamon Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 20001 1527 Ninth Street, N.W. (Son) Isaiah McCall, Jr. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 2-6-09 Bettsville, Md. Chesapeake Crematory 4 □ Donation 5 □ Other 22. Name and Address of Facility 21. Signature of Fursial Service W. 3447 lath Street, N.W. Washington, DC 20010 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artemosclerotic Candiovascular **Physician** 4 earls disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burlai-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown In Fairchion Rashiratury Be Completed anoxic Encephalopail 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Stape Renal Disease 1☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No director, 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours aff

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 27, 2009 VELOSBURY Rd HYATTSVIlle MD 2078 DEVORE MA

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0 3 2009

			For State Registrar	State of Ma	aryiand		rtificate of			entai m		.2009	05	135
	Dhyaiair		1. Decedent's Name (First, Mid	de, Last)						2. Date of D Month	eath Da	y Year	3. Time of	
	Physicia /Medic		Delores B.	Thomas					4.0-4	02	02		6:20	a _M
	Examin	er	4a. Facility Name (If not institut				4b. City, Town, or	_	on of Death			County of Deat		
	Funeral		Prince George 5. Social Security Number	s Hospital Ce	enter je <i>(In yrs. l</i> as	st birthday)	Chever	If Unc	der 24 Hrs.	8. Date of B			hplace (State	or Foreign
П	Director		579-34-3223 Usual Residence of Decedent	1□ M 2Å F	79	Yrs.	Months Days	Hour	rs Min.	03/21			ean, VA	
	land ow		10a. State 10b. Coun	у	10c. City,	Town or Lo	cation						10d. Inside C	ity Limits
	Mary Fied	ţo	MD Princ	ce Georges	Capi	itol F	leights						1X Yes	2 □ No
	or 28g	Director	10e. Street and Number	e ocornes	1		10f. Zip Code				10g. Ci	tizen of What Co	untry?	
	23a c		7404 Drumlea					743				USA		
	er dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic an, Mexi	Origin? (Spe ican, Puerto I	city Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		
5	rs afte	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🎛 Divorce	If Yes, Give	NO		1 □Yes 2 ☒ No	Spec	cify:			Specify: R1	ack	
ž	be flied within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, tre Madical Evaminar must be natified at		15 Deced	ent's Education		16a. Dece	dent's Usual Occup	ation	no at of working	200	16b. K	(ind of Business/		
7	thin 7: re. man "n	Completed	(Specify only nigital Elementary/Secondary (0-12)	cest grade completed) College (1-4or 5	5+)	life.	kind of work done DO NOT use retired	dunng n d)	nost of workir	ig		artment		
7	ed wil ygien her th t, the		12			Mai	l Clerk_	10.11		/First 141441		ense Int	ell. Ag	gency
2	be fill ntal H ed ott	Be	17. Father's Name (First, Middl							(First, Middl		i Surname)		
Ž	hould id Me mark matic	ဥ	Herbert Hill 19a. Informant's Name/Relatio			19b Mailir	ng Address (Street		uline mber or Bura	Jacks		or Town. State.	Zio Code)	
<u>8</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene than "natural", or items 23a or 28a-f show other traumatic event, it o Mosical Evaninar must be notified at		Maxine Allen -		Ī		Green Fi			Rock I			732	
ກົ	s 1 ar		20a. Method of Disposition		20b. Pla		sition (Name of matory or other place			ate		ocation - City or	Town, State	
2	Page nent c int; if		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 ☐ Removal from State (Specify)			1n Cemete		02/05	/2009	Bren	twood,	MD	
Dalimio	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once.		21. Signature of Funeral Service	e Licensee	./) 22	2. Name and Addre	ss of Fa	cility Ft.	Linco	1n F	uneral 1	Home, I	nc.
_	205 20		Myano	ntgomeny. Ch			401 Blade					ood, MD	20722	
				or complications that caused st only one cause on each li	d the death. ine.	Do not en	ter the mode of dyli	ng, sucn	as cardiac c	r respiratory	arrest,		Approximation Interval Be Onset and	tween Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Renal									2 week	S
	Examiner			Due to (or as	-	ence oi):							1 mont	h
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as		ence of):							1 mone	**
	ecutec and transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	c. Cardio									2 year	s
0/00,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al E	, occurring an occurry and	d Sepsis		since oi).						1	3 week	s
00	tificate ig phy as the	ledical		0.										
S C C	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregnanc	су			8	23d. Date of de Month	-	Year
5	the dea / the al	Physician/M	1 ☐ Yes 2 🖺 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of de	ath 5[Other (specify) _					Month	Duj	
τ. Γ.	that the	by Ph	Part II. Other significant cond	itions contributing to death t	out not result	ting in the u	nderlying cause giv	en in Pa	art I.	23e. Did	l tobacco	use contribute to	the cause of	death?
ecords,	quire; en sig uld be	q pa					***			1 🗆	Yes 2	M∑ No 3□P	robably 4	Unknown
၁	law re as be 2 sho	Completed								24a. Wa	opsy	24b. Were a	utopsy findings	available cause of
	The cate h	Com								per 1 □ Yes	formed?	death? o 1 ☐ Yes	2 □No	
VII	ician certifi ector,	Be	25. Was case referred to medi examiner?	Hospital			at 3 🗆 DOA Oth	or.		(Check only				
5	Phys r this ral dit	5.	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Ini	ury 2	28b. Time o	of 28c. Inju	rvat		me 5∐Re 28d. Describe		6 ☐ Other (Spe iry occurred	ecify)	-
0	nding tth. ;: Afte e fune	atior	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inve	ding (Month, Da stigation	ay, Year)	Injury	M 1 🗆	k?]Yes 2	2 □No					
DIVISION OF	r Atter ter dea Irector	Certification: To	3 ☐ Suicide 6 ☐ Cou	rmined Zoe. Place of III	jury - At hon tc. (Specify)	ne, farm, sti	reet, factory, office		:		(Street a	and Number or R te)	ural Route Nur	nber,
2	pital o		29a. Certifier 1 X Certif	ying Physiclan: To the best	t of my know	dodgo dogi	th occurred at the ti	imo dat	a and place	and due to th	o cause	s) and manner a	s stated	
	Hosp 24 ho Fune etely	Medical	(Check only 2 Medic	al Examiner: On the basis of and manner st	of examination	on and/or ir	nvestigation, in my	opinion,	death occurr	ed at the time	e, date ar	nd place, and du	e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of cert	fier A	111/	11/1/	29c. Licens					ate signed (Mon		
			porte	uf Jan	uli	WY.	20	05	-821-	3	2	-/3/9		
1	5		30. Name and address of pers							0.5				
K			Farhad Jamali 31. Date filed (Month, Day, Yea	ar) 32 Begist	rar's Signatu	ire	Cheverly	, MI	207	85				
	Sta Registr		FEB 0 3 2009		. pa	العص								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2/9/09 M.S. Kent Co 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Kunc ebruar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** talcenter hester River Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours Min. **™** M 2□ F Days 7/23/1943 213-42-0758 MD 65 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Exandrer must be notflied at 1 XYes 2 No CHESTERTOWN Directo MD KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21620 USA 109 FIRST ST. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. Specify: 2 BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the angles. PUBLIC WORKS FOREMAN PUBLIC WORKS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET WARNER RICHARD TOLSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 109 FIRST ST. CHESTERTOWN, MD 21620 SHIRLEY P. TOLSON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/13/09 RICH NECK CEMTERY CHESTERTOWN, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service Licenses 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arcinoma /Medical Due to (or as a consequence of): Examiner neumon Sequentially list conditions, if any, leading to irrimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate has birector, page 2 sl autopsy 1 ☐Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ix Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No eral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO yeur who completed cause of death (Item 23a) (Type, Print)
OBAYOMI, Chester River Hospital Center, 30. Name and address

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Anthonia Ugwu 22. 2009 0145 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery 7. Age (In yrs. last birthday) 63 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🔀 F Director 217-55-6553 01/02/1946 Nigeria Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County items 23a or 28a-f show event, the Medical Examiner must be notified at Md. Prince Georges Lanham Director TXETYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10412 Storch Drive 20706 Nigeria Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Black Ď 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private Duty 12th Pages 1 and 2 should be filed vent of Health and Mental Hygis ant: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses Ahanaonu Nwanyinka Ahanaonu traumatic ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tragonce. Juliana Ugwu (Daughter) 10412 Storch Drive Lanham, Md. 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/20/2009 Family Cemetery Mbaise, Nigeria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 23a. Part is inter the disclase, or complications the caused the de the ship of or heart failure. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examine Sequentially list conditions, if any leading to it, modicing cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or as a consequence of) use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. nding physicien Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Year Month Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2/AN0 1 □Yes 2 5 eral Director; After this certificated in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🖫 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, State Registrar

Dire

1. Decedent's Name (First, Middle, Last)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Isaac

Maria Cecilia Vasco/Wife

4 ☐ Donation 5 ☐ Other (Specify)

ature of Funeral Service Licensee

1 Burial 2 Cremation 3 Removal from State

12

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 ☐Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27 Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

disease or condition resulting in death)

IF FEMALE:

Cesar

15. Decedent's Education (Specify only highest grade completed)

4a. Facility Name (If not institution, give street and number)

Completed

Be 2

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

						- 1							1	
	Shady G	rove Ad	lventist	Hosp	oital	_	Ro	ckv:	ille				M	ĺ
	5. Social Security N	umber	6. Sex	7. Age	e (In yrs. last b	oirthday)	If Under	1 Year	If Under		8. Date	of Birth	Vaasi	
	212-51-94	495	1 X M 2 □ F		62	Yrs.	Months	Days	Hours	MIII.	L '	-	1946	,
	Usual Residence of	Decedent												
	10a. State		10c. City, Town or Location											
ctor	Maryland	Montg	omery		Ga:	rsbur	sburg							
ire	10e. Street and Nun	mber					10f. Zip	Code				1	0g. Citiz <i>e</i> i	r
ā	17625 To	pfield		20877							1			
ne	11. Marital Status			t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes.)						pecify Yes	or No-	14.		
1	1 🗌 Never Marri	ed 2 Marr	ied 1 □Yes	2 N	10	1						,		
ð	3 Widowed	4 Divorced				'	LALITES 2	.□ NO	Specify.	Ecua	adora	n	S	-
	by Funeral Director	5. Social Security N 212-51-9 Usual Residence of 10a. State Maryland 10e. Street and Nur 17625 To 11. Marital Status 1 \square Never Marri	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County Maryland Montg 10e. Street and Number 17625 Topfield 11. Marital Status 1 Never Married 2 Mary	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10e. Street and Number 17625 Topfield Drive 11. Marital Status 1 Never Married 2 Married 1 1 1 9 8 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10e. Street and Number 17625 Topfield Drive 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Montgomery 10e. Street and Number 17625 Topfield Drive 11. Marital Status 1 Never Married 12 Married 11 Yes 25 No 11 Yes 25 No 11 Yes 25 No 11 Yes 25 No 11 Yes 25 No	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc Maryland Montgomery 10e. Street and Number 17625 Topfield Drive 11. Marital Status 1 Never Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Married	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. Street and Number 17625 Topfield Drive 17625 Topfield Drive 11. Marital Status 1 Never Married 10. Never Married 10. Security Number 10. City, Town or Location 22. Street and Number 10f. Zip 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 1 Never Ma	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. Street and Number 10f. Zip Code 17625 Topfield Drive 11. Marital Status 1 Never Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Never Married 1 Never Marrie	5. Social Security Number 212-51-9495 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year 1 If U	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. Street and Number 10c. Street and Number 11d. Marital Status 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Sex 1 Never Married 1 Never	5. Social Security Number 212-51-9495 1 M 2 F 62 Yrs. 63 Yrs. 64 Yrs. 64 Yrs. 64 Yrs. 65 Yrs	5. Social Security Number 212-51-9495 1 M 2 F 62 Yrs. 63 64 Yrs. 64 Yrs. 65 65 65 65 65 65 65 6	5. Social Security Number 212-51-9495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. Street and Number 10c. Street and Number 11d. Marital Status 11d. Marital Status 11d. Marital Status 11d. Never Married 11d. Security Number 11d. Security Number 11d. City, Town or Location 11d. City, Town or Location 11d. State 11d. City, Town or Location 11d. State 11d. City, Town or Location 11d. State 11d. City, Town or Location 11d. Marital Status 11d. Marital Status 11d. Never Married 11d. Security Number 11d. City, Town or Location 11d. State 11d. City, Town or Location 11d. State 11d. City Code

College (1-4or 5+)

16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Furniture Assembler Furniture 18. Mother's Name (First, Middle, Maiden Surname)

Julia Vasco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16a Decedent's Usual Occupation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

17625 Topfield Drive, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

Reg. No.

Day

03

4c. County of Death

10g. Citizen of What Country?

Specify:

Montgomery

United States

14. Race - American Indian, Black, White, etc.

0645

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

Ecuador

White

Santos

Approximate Interval Between Onset and Death

Months

Year

2. Date of Death Month

February

2/6/2009 Souls Cemetery Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home 40 East Deer Park Dr., Gaithersburg, MD.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Refrectory Myelogenous Due to (or as a consequence of) Due to (or as a consequence of)

Due to (or as a consequence of):

3 Ectopic pregnancy 5 ☐ Other (specify)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔂 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 □Yes

23d. Date of delivery

Day

Month

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1Xinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be

#327

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

Banner

February 03, 2009 MD060335

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bannen Prince Philip

Date filed (Month, Day, Year) Registrar's Signature FEB 04

Registrar DHMH 17 Rev 1/2001

6

PO

State

09-00920 Ronald W. Wasl	aina	Please Type or Print in Black Indelible Ink. Ensure All Copies		ble.	
Ruffald VV. VVasi	_	on State of Maryland / Department of Health and Mental Hygi - For State Certificate of Death			00 00 0
Physicia		1. Decedent's Name (First, Middle Last) 2.1	Reg Date of Death	201	3 Time of Death
Medical Exami		RONALD W. WASHINGTON	Month [January 31,	Day Year 2009	1615 hrs
(4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
		Ft. Washington Hospital Ft. Washington	, Data of Diah	Prince Georg	
Funeral Director		Months Days Hours Min	3. Date of Birth 06–18–1	Fore	eign Country)Orange Co
Director		250 00 7070 T_M 2_7 55	00-18-1	.955	country of all ge CO
any	ŀ	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
≱]		Maryland Prince George's Fort Washington			1 ³ Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	ountry?
the M a or 2		8710 Fran Del Drive 20744		USA	
with rus 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric		14. Race - Am White, etc.	erican Indian, Black,
r death or ite	Ë	Never married 2 M married 1 Yes 2 No	2011, 2121,	Specify: B1a	
s afte ral",	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of works)	k done	16b. Kind of Busines	
2 hour "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		-	181A
136 thin 7 than edica	ם	12th Contractor		P.G. Co.	Government
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S	17. Father's Name (First, Middle, Last) 18.Mother's Name (Fi			
121 be fill ental F erked	å	unk Margare			
D 21 should ind Mer is man	To	19a. Informant's Name/Relationship (Type, Print) Marian Banks Washington/wife 19b. Mailing Address (Street and Number or Rural Rural Parts of Par			ate, Zip Code)
, MD and 2 sho ealth and em 27 is	-	0 1		20c. Location - City	or Town, State
Ore ges 1 a t of H : If it		1 Burial 2 *Cremation 3 Removal from State crematory or other place)		A 1 1	W:inin
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>		4 Donation 5 Other Specify: Metropolitan Crematory 02-03 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	5-09 p	Alexandria	a, Virginia
Ba perm Depa Impo		Jack Wilson Cedar Hill FH 4111 P	A Ave.	Suitland	,MD 20746
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Death
, xaiiiiiei		or condition resulting in death) Due to (or as a consequence of):			
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	nin	cause. Enter Underlying Cause (Disease or injury that initiated c.			
eđ nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transit	cal	d. UNPENDED AMENDED			
30, te be e ysicia		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	verv
68760, certificate be nding physici se as the buril	an/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance	у	Month	Day Year
Box 6 e death ce the attend	sici	4 Pregnant at time of death 5 Other (Specify)			
the de	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
P.O.	þ	Chronic alcohol abuse	1 Yes	2 No 3 F	Probably 4 V Unknown
ds, equire	eted		24a. Was a	n 24b. Were	autopsy findings available
COF law r has b e 2 sh	ompleted		autops	ned? death	
Division of Vital Records, P.O. Box 68760, vinhin 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	၂ ပ	25. Was case referred to medical 26. Place of Death (Check onl	1 Yes 2	No 1	Yes 2 No
/ital sician is cert	o Be	examiner? Hospital: Innation 2 PEP/Outnation 3 DOA Other, Nursing b		Residence 6 01	her:
n of V ding Phy After th funeral	-	1 ✓ Yes 2 No Impater 2 € Electropater 3 € Electropater 4 € Electropater 5 € Electropater 5 € Electropater 6 € Electropater 6 € Electropater 6 € Electropater 7	8d. Describe h	ow injury occurred	
	ertification:	Natural 5 Pending			
Division rale or Attendiners after death.	iji	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	8f. Location (S or Town, St		Rural Route Number, City
Divisior pital or Attencours after death eral Director: filled in by the	Cert	4 Homicide determined (Specify)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	ue to the cause	e(s) and manner as s	stated.
To the Hos within 24 h To the Fun	Medical	and manner stated.	ne time, date a		
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (February 1, 20	
		to the second		, coloary 1, 20	
0 3		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201	1	
100	tate	31 Date filed (Mooth, Day Year) 32. Registrar's Signature			<u>-</u>
Regis					
DHMH 17 Rev 1/2	2001	ORIGINAL			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lec Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UA Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Director March22, 1954 488-58-7109 Usual Residence of Dece Missouri 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County tv∏Yes 2∏No ir than "natural", or Items 23a or 28a-f st the Mediral Examiner must be notified PG Maryland Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9565 Sylvan Still Road Apt#P 20723 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-16 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than Letter Carrier US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked c any Injury or other traumatic. Mary L. Gray Carl L. Williams Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Lee williamsII (son) 9093 Phillip Dorsey Way Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State [□]2ზ09 X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Leavenworth, Kansas Leavenworth National February13 5 Other (Specify) 4 □ Donation 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility 4217 9th street NW Washington dc 20011 Marshalls Funeral home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of Examine death certificate be executed burial-trans Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2[**D** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and file of entifier 29c. License number 29d. Date signed (Month, Day, Year) P23121 01-28-2009

State Registrar 10 N. greene Street, buth more, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Ameno#7.PerFHPGC2-5-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Month **Physician** 1838 M Janu 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ho_G nevell If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 12 M 2□ F $74 \, \text{Yrs.}$ 577.46.554c Director South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Kayes 2 □ No Landover Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 2 any injury or other traumatte event the 18 marked of the 18 marked or 18 marked Sheri road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed umber 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Mnnie ၉ uncan 45 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jannar 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Me hod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville 4 ☐ Donation ure of Funeral Service Licen 21. Signa 4594 Beech Road Freeman Funeral Services Temple Hills MD QUILL Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. P rt1. Inter the disease, or co s ock, r heart failure. List on Approximate Interval Between Onset and Death Immediate vause (Final disease or condition resulting in death) Cardio vascular **Physician** Atheroseleratic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to influed atte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. should be detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an N autopsy performed page, 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

State Registrar 31. Date filed (Month, Day, Kear)

FER 0 5 2009

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day L. Wilkinson Etta February 2, 2009 7:34 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Days Hours Months 494-30-4303 80 2-1-1928 KansasCity, MO Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Wheaton 1X Yes 2 □ No MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20902 United States 11901 Georgia Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. 1 ☐Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4or 5+) Elementary/Secondary (0-12) Psychiatric Social Worker Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) G. Faye McGee Vernon Wilkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Takoma Park, MD 20912 7600 Maple Ave. Apt # 407 Verna F. Thomas (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory 2-5-2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service icensee 3401 Bladensburg Road Brenwood, MD 20722 Dupo nous 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dementia disease or condition resulting in death) Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of) Depression resulting in death) Last Due to (or as a consequence of): Lachexia 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 2 🗀 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

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the Medical

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Item 27

1 and 2 should be fill Health and Mental H em 27 Is marked otf

Pages 1 Department of Important: If It any Injury or o Director

Funeral

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Completed

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death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

death certificate be executed burial-tra the. the signed by the law requires that page 2 certificate To the Hospital or Attending Physician:

this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical

After th funeral

Box 68760

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Division of Vital Records,

Exam Physician/Medical \$ Completed Be Certification: To

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IF FEMALE 23b. Was decedent pregnant 1 ☐ Yes 2 X No 9 Unknown

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 X Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

29c. License number 20056063

Silver Spring, MD 20910

29d. Date signed (Month, Day, Year) D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd. O. Nagi, MD

31. Date filed (Month, Day, Year) . 32. Registrar's Signature

State Registrar

		4	For _ State		State	of Ma	ryland		rtment		alth and	Menta			009	051	43
		_	Registrar	- /First Middle	(ant)	Cer	inicate	OID	eau i	2 Date	Reg. No. C U U			3. Time of De	eath		
Phy	/sicia	_	1. Decedent's Name (First, Middle, Last)										Month Day Year				
	ledica		Donna F		4b City 7	own orto	ocation of Dea	th I	1 - 29 -2009 4c. County of Death				<i>γ</i> Ρ				
Exa	amine	r 4	a. Facility Name (numper)							Montgomery				
		-	Alfredho 5. Social Security N		ercare 6. Sex	7. Age	(In yrs. las	t birthday)	Si.	ver 1 Year	Spring f Under 24 Hr	s. 8. Date	e of Birth onth, Day,	Mo:	9. Birth	nplace (State or F	-oreign
Fund			230–30–96		1 □ M 2 X F	"	81	Yrs.	Months	Days	Hours Mir	5/5	nth, Day, / 1927	rear) 1		intry) Virgin	ia
	JUI		Jsual Residence o														
EXILIMORE, INIXIVIAING Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan net is ust be notified at	Ħ		Ioa. State	10b. County				Town or Lo	cation							10d. Inside City	
	ge .	ا غ	Maryland	Montgom	ery		Derv	wood								1 XYes 2	
	to .	Directo	10e. Street and Nu	mber					10f. Zip	Code			10	g. Citizen	of What Cou	untry?	
th with	tg !	<u>=</u>	17746 M	illcrest	Drive					20855				ISA			
deal	100	Funeral	11. Marital Status		12. Was D Armed	ecedent E Forces?	ver in U.S.	13. \	Vas Deced f Yes, spec	ent of Hisp ify Cuban,	oanic Origin? (Mexican, Pue	(Specify Ye erto Rican, e	s or No- etc.)		Race - Amer Black, White		
after or it	min I		_	ried 2 Marrie	If Yes,		0		I∐Yes 2		Specify:			Spe	ecify: Whi	ite	
5-0036 72 hours aff	<u>a</u>	d by	3√∑ Widowed 4 Divorced Year or Dates:										1	6h Kind c	of Business/I	ndustry	
72 h	dica	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kir (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)										OD. INIIG	nd of Buomood, madoury				
within within than	No.	Completed	Elementary/Second 12	ondary (0-12)	College	e (1-4or 5-	+)		emake	•				Pri	vate		
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and d be file ental H ced oth	e e e	m	Arthur I								Mary H	. Rad	er				
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Mal d2st d2st than t7 is r	trau		Paul Whit		,						t Dr.,				20855		
Heal Heal	the		20a. Method of Dis	sposition			20b. Pla	ce of Dispo	sition (Nan	e of	1	Date	2	0c. Locati	ion - City or T	Town, State	
ages ant of t: If it	y or			☐ Cremation 5 ☐ Other (Sp		om State					ry 2/1	/2009		Brant	wood,	MD	
Daltimore Surmit. Pages 1: Department of He	uniu.	+	21. Signature of F			11	PIT C.				of Facility F						
	ong	1		111		KK,	1	200			sburg R					20722	
		-	23a, Part 1, Enter	the disease, or	complications th	at caused	the death.								1	Approximate Interval Between	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Cerebrovascular Accident											Onset and Death			
Physic /Med	_		disease or conditi	ion	_ a.				Accı	dent						2 weeks	
Exami	_						a conseque iosce		c								
		<u>-</u>	Sequentially list of	onditions,	b		a conseque										
ited	nsit	틭ㅣ	cause. Enter Underlying Cause (Disease or injury Dementia													Years	
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8760 ate be o	the burial-transit	dical			L d A	d. Alzheimer's Disease										Years	
. Box 68/60, death certificate be executed e attending physician and	s the	ğ			U												
Box 6 eath certific	rse a	Physician/Me	IF FEMALE: 23b. Was decede	nt pregnant			of pregnan		76					23d	l. Date of del	livery	
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tuires n sig	pi pi											- 10	1 □ Ye	s 2 🗆 N	No 3∏ Pi	robably 4 🗖 Ur	iknown
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tai m:T	or, pa	ပိ	25. Was case refe	erred to medical							26. Place of D				1 🗆 103	2 🗆 110	
Division of Vital Records, or Attending Physician: The law requires that death. Director: After this certificate has been signe	.≝	20	examiner? 1 ☐ Yes 2		Hospital:	I ∏ Inpatie	ent 2 🗆 E	R/Outpatie	nt 3 □ D0	Other	,.				Other (Spe	city)	
Vision of Attending Phy. er death. ector; After this	eral	일:	27. Manner of De	ath	28a. C	ate of Inju	iry 2	28b. Time o		28c. Injury Work?	at	28d. D	escribe ho	w injury o	ccurred		
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/iSi Atter r dea r dea	d in by the f	<u>=====================================</u>	3 Suicide	6 ☐ Could r determ	incd 200. F	lace of Inju	ury - At hon	ne, farm, st	reet, factor	, office		28f. Lo	cation (St	reet and N	lumber or Ri	ural Route Numb	er,
Div alor A safter il Dire	.⊑	Certification:	4 Homicide			anumy, et	c. (Specify)						,	, ,			
E Hospital 24 hours a	y filled		29a. Certifier	1 Certifyin	g Physician: To	the best	of my know	vledge, dea	th occurred	at the tim	e, date and pl	ace, and du	ue to the c	ause(s) ar	nd manner a	s stated. e to the cause(s)	
Div To the Hospital or within 24 hours afte To the Funeral Dir	plete	edical	(Check only one)	∠ wiedical	and i	manner sta	ated.										
**************************************	com	ž	29b. Signature ar	nd title of certifier	1	1 2.		210	29	c. License			2		signed <i>(Mont</i> /2009	h, Day, Year)	
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			For State Registrar	State of Ma	ryland / [Depa <i>Cei</i>	artment of F rtificate of L	lealth an D <i>eath</i>	nd Men		ene g. No. 20	09	05144
ı	Physici	an	1. Decedent's Name (First, Middle, L	,						Date of Death Month	Day	Year	3. Time of Death 1:05 p _M
	/Medic		4a. Facility Name (If not institution, g	Romaine Meeds	Warren		4b. City, Town, or	Location of D		oruary	02 4c. County	of Death	1.03 PM
	Examin	er	206 E. Church				, ,	Mt. Airy			40. County		roll
	Funeral				(In yrs. last bir		If Under 1 Year Months Days	If Under 24	Hrs. 8. E	Date of Birth Month, Day,	Year)		lace (State or Foreign
	Director		579-09-1410 Usual Residence of Decedent	ILIM ZMF	94	Yrs.	Dayo			cember 2			Maryland
	/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation					1	0d. Inside City Limits
-UU36 hours after death with the Maryland	a-fsh	ctor	Maryland Mon	tgomery			Si	lver Spi	ring				1 ☐Yes 2 🖾 No
	iff the	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	What Coun	itry?
	sath w	eral	211 Williamsbur			T ;		20901				U.S	
0	fter de ritem	Funeral	 Marital Status Never Married 2 ☐ Married 	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No		13. (Vas Decedent of H f Yes, specify Cuba	ispanic Origin in, Mexican, P	1? (Specify Puerto Rical	Yes or No- n, etc.)		e - Americ k, White, e	
15-0036	hin 72 hours after death with the Marylar e.e. "natural", or liems 23a or 28a-f show Medical Evarinat must be notified at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2⊠No	Specify:			Specify	<i>'</i> :	White
<u>2</u> -C	ina ina	Completed	15. Decedent's E (Specify only highest g	(Give	dent's Usual Occup kind of work done o	furing most of	f working	1	6b. Kind of Bu	usiness/Inc	dustry		
7	₹ 6 ₹	dmc	Elementary/Secondary (0-12))	life. L	OO NOT use retired			1		O II		
20		Be Co	17. Father's Name (First, Middle, Las	3 :t)			Homema		Name (Fir	st, Middle, Mi	aiden Surnam	Own H	ome
Maryland 2	0 0 0	To B	William	Pusey Meeds					Ro	omaine T	indell		
lar)			19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailin	g Address (Street	and Number o	or Rural Ro	ute Number,	City or Town,	State, Zip	Code)
	s 1 and of Health item 27 other to		James T. Warren 20a. Method of Disposition	- Son			Zion Road,					0: =	
ğ	e = to		1⊠ Burial 2 ☐ Cremation 3				sition (Name of natory or other plac	i	Date		Oc. Location -	·	
Baltimore,	permit. Par Departmen Important: any Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Gate o	22	aven Cemete . Name and Addres	s of Facility	2/06/20	- 1	Silver S	pring	, Maryland
ă	a in per	1 1	> also	Donnel	ℓ		nes-Rinaldi 800 New Ham				Spring	Marv	land 20904
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line.										Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Acu	ite	Re	spirate	ny	Fau	luce			Onset and Death
المرا	/Medical Examiner		resulting in deality	Due to (or as a	consequence	of):	4000	- (2.11.	AP.			
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	1 Coan	- 6	aun			-			
	cuted nd ransit	Examiner	that initiated events	· Co	- C	hronic	0681	truet	re Pu	Con- D	75-		
/60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence of): d. Hy Perten									
200	cate phys the	dical	•	d	peue	wil						-	
ROX P	w requires that the death certificate is been signed by the attending physi should be detached for use as the I	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy						23d Dat	te of delive	in.
Ž	death	sicia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)	<u> </u>		Month Day			•
7. 5	at the	Phys	9 🗆 Unknown (
ds,	signer	þ	Part II. Other significant conditions	contributing to death but	not resulting in	the ur	iderlying cause give	en in Part I.			1.6		e cause of death?
(1	- 9 %	Completed							-	1 ☐ Yes			ably 4 Unknown
Ě	ne law e has t	dmo			<u>-</u>			_	— i	24a. Was an autopsy performe			psy findings available npletion of cause of
Vital	an: I	(a)	25. Was case referred to medical	T				26. Place of		1 □Yes 2			2 □ No
> TO	nysici his ce i direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatien	ıt 2 ☐ ER/Oı	ntpatien	t 3 DOA Othe				ce 6 Oth	er (Specify	Daughter's
ב	ing P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28b.	Time of njury	28c. Injury Work	/ at ?	28d. I		injury occurr		
DIVISION	death death stor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not	be 200 Place of Injur	At home to	rm otro		res 2 □ No					
2	allor A after Direction by	Certification:	4 Homicide determined	building, etc.	(Specify)	riii, Sire	et, lactory, office		201. L	ocation (Stre	set and Numb State)	er or Rura	l Route Number,
	to the hospital or Adath, within 24 buous after death, within 24 buous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 3 of the funeral director and funeral director.		29a. Certifier (Check only 2 Medical Exa	Physician: To the best of milner: On the basis of	f my knowledge	e, death	occurred at the tin	ne, date and p	place, and	due to the car	use(s) and ma	anner as s	tated.
	the H hin 24 the F nplete	Medical	One)	and manger state	ed.	IG/OF IFN							
	0 ≥ € ©	_	29b. Signature and title of certifier	Kurkhis			29c. License	2266 2115	7	296	d. Date signed	-09	Day, Year)
	12		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, F	Print)	2	,, I	Nagii	J Sur	/ ai=	M D
			4212 Ridge	Rd, wes	7 murs	tes	- mel-	2115	5/	.,4911	o. bul	eja,	п. И.
	Sta		31. Date filed (Month, Day, Year) FEB 0 4 2	32 Registrar									
	Registra	al	1 50 4 7	Cerewa.	B.,	40	Kel						

State of Maryland / Department of Health and Mental Hygieney 0 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 835 PM Month **Physician** Clara Blanche WATSON 2009 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 55 East Washington Street Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Year) 1 □ M 2 🖾 F 219-52-1315 1948 Pennsylvania Nov. 12, 60 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10b. County ar than "natural", or items 23a or 28a-f show 1 Yes 2 No Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 55 East Washington Street Apt 914 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Meany Injury or other traumatic event, the Meany Injury or other traumatic approximations. College (1-4or 5+) Elementary/Secondary (0-12) private club bar tender 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche E. Burton Alvin M. Linn, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 55 East Washington Street, Hagerstown, Maryland 21740 Jack Myers - companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 9, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colo~ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

E Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 Ø No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 100 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) redied Comos (necle 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 9 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2820 •Month Elizabeth Wood 7:41 -ebruar Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month Day, Year) 5 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Months Days Min. 1 □ M 2 🕏 F Hours Maryland 93 216-22-2664 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 TyYes 2 □ No Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 USA # 6 Oak Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Manager Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry C. Bowie Blanche Garner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9527 Spring Hill Newtown Rd. La Plata, MD 20646 William Wood/Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Rest Cemetery 2/5/2009 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 ARTHARTICE CHOLL'S FUNERAL HOME, P.A. M00945 211 St. Mary's Ave.La Plata,MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Was case referred to medical 1 □ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

Physician /Medical Examiner Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ည

Examine

Certification: To

Medical

the

filled in by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ever. In act to confile any once.

Maryland 212

Baltimore,

attending physician and for use as the burial-tran signed by i After this certificate To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Be Completed

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

examiner? 1 Tes 2 No 27. Manner of Death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LA PLAM. MD 20646 317 118 LAGRANCE AV P.O. BOY1 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible links Ensure All Capies Are Legible. amend #10a-f Per Inf G894 8 04/09 Jh

Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:45 PM Donald Roberts Wagner 2009 Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min Months Days Hours 1 ☑ M 2 ☐ F 78Yrs 103-24-4452 July 19,1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State Florida 10h County Annabarton item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "hed cal Examiner must be notified at Manatee XXYes 2 No **Funeral Director** Maryland Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 949 Waterside Lane 2560 Glen 21401 34209-7729 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1953-55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ National Sales Manager Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Nagel Nelson Wagner ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a 2560 Glen Cove, Annapolis, Maryland 21401 Loveday A. Wagner / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any injury or o 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Kalas Crematory 1-31-2009 |Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signature of Funeral 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending ph for use as the IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No nours after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052023 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Encarnacion D. Romero, 122 Defense Hwy., Suite 200, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 2 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** 01:00 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICONICO SALISBURY PENINSULA Regional MEDICAL If Under 1 Year | If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) 1**X** M 2□ F Months Days Hours Min 3 MD 214-66-8087 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Examinat must be notified at 1XYes 2□No **Funeral Director** Wicomico MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2180 SA 1008 Lake Stree 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Blace 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Verdu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wright \mathcal{N} i χ or ၉ Johnnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mright Salisburg Mary MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Macedonia 4 Donation 5 Dother (Specify) am W. Isubula Street 22. Name and Address of Facility Bennie Smith MO 31801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sarcoidosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Terminal Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi DM and Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Stage Chronic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pheumonia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐No after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🖸 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

28

State Registrar 31. Date filed (Month, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rysistrar's Signature

D 57952

Salisbury

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MD21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00893 State of Maryland / Department of Health and Mental Hygiene Gaile Zimmerman 1. For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 30, 2009 Year 1028 hrs **Medical Examiner** Gaile Zimmerman 4b. City, Town, or Location of Death c County of Deat 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** oreign Washington Days Months Min. Director 578-90-8143 48 March 20,1960 M 2X F Yrs DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1XX Yes 2 No Maryland Prince George notified at once District Heights with the Maryland 10g. Citizen of What Country Zip Code 10e. Street and Number United States 20747 1905 Winter Green Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 12. Was Decedent Ever in U.S. 11. Marital Status þ Armed Forces? death v 1 X Never Married 2 Married must x Yes Sperify: Black Divorced Yes Give Year Yes 2 X No specify. Widowed marked other than "natural", c event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Cleaner Results, Inc Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene. MD 21215-0036 (Dry Cleaning) Cleaner we1th 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) marion Zimmerman Leon Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is n traumatic 7407 Calder drive, Capitol Heights, MD 20743 Denise Zimmerman/Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, crematory or other place) February artment or apportant: If Burial 2 XCremation Removal from State 18,2009 Riverdale Park Riverdale Park, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Daniel W. Harrison 2. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd Se, Washington DC 20020 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical Atheoslcerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical 23a, PII, 27, permE, g888 2/23/09 TT X UNPENDED AMENDED sician a Records, P.O. Box 68760, The law requires that the death certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: the attending phy: ed for use as the b 23b. Was decedent pregnant in the Month Day Year Fetal death Live birth nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Š No 3 Probably 4 ✔ Unknown Cocaine use Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has lety filled in by the funeral director, page 2 st performed? death? 1 V Yes Yes 2 26.Place of Death (Check only one 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other DOA Nursing Home 5 Residence 6 Inpatient 2 PER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

CR 2

Date filed (Month, Day, Year)

FFR 1 2 2009

32. Registy rs Significant

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD

vor. 50

111 Penn Street, Baltimore, MD 21201

O.C.M.E

January 31, 2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05150 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month A M 8, 7:55 Mary Root Zerby February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45870 Skipjack Drive Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 009-32-3837 63 December 28,1945 **Director** Usual Residence of Decedent the Maryland 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner and be inclined at once. **Funeral Director** 1 ☐ Yes 2X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45870 Skipjack Drive 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Joseph Root ပ Edna Marks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kermit Richard Zerby / Husband 45870 Skipjack Drive Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 13, Leonardtown, Maryland Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, F P.O. Box 270 Leonardtown, MD 20650 P.A. Kenneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BSTRUCTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by OBSTRUCTIVE LUNG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending after death.

Director: Af in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Nedical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO KODALI M.D. 14090 HG Trueman Road, Suite 2300, Solomons, Maryland 20688 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 2009 1:05 P M Joseph L. Zentgraf 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Berlin Atlantic General Hospital Worcester 8. Date of Birth (Month, Day, Ye 3/6/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 1**X** M 2 ☐ F 79 212-26-8955 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No MD Worcester Ocean Pines 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 145 Sandyhook Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □XYes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐XNo Specify 3X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard Zentgraf Margaret S. Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony L. Zentgraf, Sr. 25 N. Hairgrove Lane, Camden, DE 19934 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 2/6/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Inter the disease, or complicate shock, or heart failure. List only one of is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to fr as a consequence Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 HUnknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 🖃 No 1 □Yes 2 ☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician /Medical Examiner Examiner

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Physician

Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Macical Examiner must be notified at

/Medical

Funeral Director

Be Completed by

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the attending physician and hed for use as the burial-tran

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the nexal Director: cate has been signed by page 2 should be detach funeral director,

Physician/Medical \$ Completed Be Certification: To

DN 1041 State Registrar 30. Name and

31. Date filed (Month

completely

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1∐Yes 2⊒Mo 27. Manner of Death 1 Hatural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53612

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on who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 8 **Physician** 2009 **AMAUWA** 11:55 PM IRENE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 8. Date of Birth (Month, Day, Yea MARCH 30 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Year) 1966 NIGERIA 1 □ M 2 □ X F 42 Director 161-78-6495 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director MONTGOMERY SILVER SPRING MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 4009 PEPPERTREE LANE USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any Injury or other trailmetin. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4 YRS NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ONYEIZU PAUL ONYEIZU PHILOMINA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 PEPPERTREE LANE SILVER SPRING, MARYLAND 20906 STEPHEN AMAUWA/HUSBAND 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State AMAUWA FAMILY PLOT 4/18/2009 ABA, NIGERIA 4 ☐ Donation _5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Fureral Service Lidensee 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTASIS BREAST CANCER /Medical Due to (or as a consequence of): Examiner METABOLIC ACIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1∐Yes 2∏No P.O. 9 Unknown 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate | 2 🖾 No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎇 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. reral Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide

within 24 hours a

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

KANWALJIT K.

2 0 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

mil

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

NAGI

1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20056063

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician Dav Jessie B. Alston М 5:00 a Feb 18, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care-Irvington Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 M 2 □ F Director 213-54-2160 74 Sep 28, 1934 No. Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 No Director N/A Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 Pennsylvania Avenue 21201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 <u>^</u> 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced Black "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the, Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legg Mason Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Alston Margaret Alston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Barkley 7827 Farmstone Court Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/21/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Western Star Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 21217
shock, or leart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 4 Donknown 1 🗌 Yes 2 No 3 Probably filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an After this certificate has autopsy performed? res 2 No To the Hospital or Attending Physician: 25. Was case referred to_medical 26. Place of Death (Check only one) examiner? A No 은 1 ☐ Yes Other: 1 Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28h Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural М 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 31. Date filed (Months, Day, Year)-32. Régistrar's Signature State Registrar

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9	be filed within 72 hours after death with the Maryland ttal Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Michael Franting at event, the Michael Franting at	/ Fur		ied 2 🔀 Married	Armed Forces? 1 Yes 2 If Yes, Give	No 1968	_	f Yes, specify Cub I □Yes 2 ☑ No	an, Mexican, Puert Specify:	o Rican, etc.)		Black, White Specify:		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Robert-130 N 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balt. county Rock Glen Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5/12/5 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days NC 1 3 M 2 □ F 55 Director unk Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than *natural', or items 23e or 28e-f show eny injury or other traumetic event, the Medical Experiment mat be multipled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No CaBarrus Concord NC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 28025 USA 255 Crowell St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ^{Specit}American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Agriculture Elementary/Secondary (0-12) Laborer 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Bell Miller Tom Boyce ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ethel Blakeney/Sister 255 Crowell St., Concord, NC 28025 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Concord, NC 2/21/09 Rutherford Mem ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Funeral Service Licenses 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** neumoma Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) physician and s the burial-transit andi One or Attending Physician: The law requires that the death certificate be executed Due to (or as a conse ue ce o Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal / the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 1 ☐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 20 No ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St . A. Alme 821 and aw

State

Registrar

31. Date filed (Month, Day, Year)

20 2009

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** $02^{\text{Month}}_{-16-2009}$ 1400 P M Barbara P. Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–18–1939 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🕅 F 093-32-7687 69 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Modical Examiliar must be notified at 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Royal Oak Dr 21014 IISA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) should be filed within and Mental Hygiene. 12 Clerical Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Powell Katherine Larwood ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau 109 Royal Oak Drive Bel Air, MD 21014 Michele Brown (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02-19-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Minules entricular /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Brown Barbara - M80322569 Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: this certificate 1 ☐ Yes 1 ☐Yes 2 \square No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After the 27. Manner of Death

1 X Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director; A 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lor A 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier

State Registrar 1716 Harford

FALLSTON MD 21047

W.W

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

M.D

State of Maryland / Department of Health and Mental Hygiene2009For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 30 PM VIa 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Hospita 1 and Genera 1964 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🗙 F Yrs. Director 216-34-6239 11-14-1939 D.C. Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Marileal Examinar must be notified at N/A MD Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 812 W. Lexington Street Completed by Funeral 21201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 34 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+)unk Elementary/Secondary (0-12) 12th Grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Deportment of Health and Menta Important: If Item 27 is marked any injury or other traumatic events. John Harrod Mary Carter ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Apt 204 Cockeysville, Vernon Brooks-Grandson Byron Lane 281 Lloyd. MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-12-2009 Owings Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, groloce L-M: Jews 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Der /Medical Due to (or as a consequence of): Examiner en a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): as the burial-transit The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. be detached 9 Unknown 9 TUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peen -24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No has certificate 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No ဥ 1 🗌 Yes 1 🗌 Inpatient 2 PER/Outpatient 3 DOA this within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2004 ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month Bay, Year) 32. Registrar's Signature State FEB20

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01294 State of Maryland / Department of Health and Mental Hygiene 2009 05158 Evelyn Belschner Certificate of Death Reg. No 1. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 13, 2009 Physician/ 0633 hrs Evelyn Ann Belschner Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min. Months Days Country) 386-48-7037 63 low Sep 19, 1945 Director Yrs 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State Yes 2 X No MD Howard **Ellicott City** items 23a or 28a-f show ust be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number 3431 Church Road 21043 U.S.A 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 XMarried Armed Forces' 1 Never Married White Yes Specify 9 2 X No specify: Yes Divorced If Yes, Give Year Widowed 16b. Kind of Business/Industry "natural", item 27 is marked other than "natural". traumatic event, the Medical Examiner 16a. Decedent's Usual Occupation (Give kind of work done ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) leted College (1-4 or 5+) Elementary/Secondary (0-12) homemaker at home Baltimore, MD 21215-0036 Compl unk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence F. Belschner Helen Emma Braun Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Gary D. Maule - spouse 3431 Church Road Ellicott City, MD 21043 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Glen Burnie, M D Atlantic Crematory, LLC Donation 5 Other Specify 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Service License Signature of Fund at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and disease, or complications **Physician** failure. List only one cause on each line Hypertensive Atherosclerotic Cardiovascular Disease 'Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine o to immediat cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical tending physician a AMENDED UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day 3 Ectopic pregnancy Month Year Fetal death 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. No 3 Probably 4 ✔ Unknown Yes 2 þ 24b. Were autopsy findings available Completed Division of Vital Records, 24a. Was an has been s prior to completion of cause of autopsy death? performed? Yes 2 V No Yes certificate page 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this rentifi-25. Was case referred to medical Be Other₄ Residence 6 Other Hospital: 1 Nursing Home 5 examiner? Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 V Natural Pending Director: Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 13, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD

OCME

31. Date filed (Month, Day, Year,

FER

ORIGINAL

32. Registrar's Signature

State

Registrar

			For	State of Maryland				Mental F	lygien	e2 ()	19	051	159
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	/Medic Examin		Charles 4a. Facility Name (If not institution, give	Enoch e street and number)		Brown 4b. City, Town, or Lo		Hebru		c. County	of Death	10.50	2 1
	Examin	E	St. Agnes +	luspital		Balti	more						
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altimor	Page ment ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State (Y) Kin	g Men	norial Pa	rk 2/2	1/09	Woo	odla	wn,	Md	
ga	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Menortant: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it was also an examinate the modified at once.		21. Signature of Funeral Service Licer	isee and	N	Name and Address	West						
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7	ı		30. Name and address of person who	completed cause of death (Item	23a) (Typ <i>e</i> ,	Print)			100	, - / , , , ,		, 200	
2.0	V		CHARLES CO	completed cause of death (Item	CA	GRIES	HUSPI	TAL	BI	2771	nor.	E n	20
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** /Medical 2009 7:14a. Howard Samuel Berryman 02 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 203 Harmison Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Director 213-58-4385 56 MD Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Expansion must be notified at Director X□Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21223 203 Harmison Street U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ites any Injury or other traumatte event, it a Medical Exaction 1 Never Married 2X Married Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Truck Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B ပ Samuel Berryman Eva Dandridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Harmison Street, Baltimore, Md 21223 Maurice Berryman-Brother altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MemorialPark 2/23/09 King Woodlawn, Md er of Funeral Service Licensee 22. Name and Address of Facility March F/H West 00 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that our shock, or hear ailure. List only one cause on each Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedi te Cause (Fir al elato Ce CARCINOMO Physician Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examine If any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and The law requires that the death certificate be exec Due to (or as a consequence of) Box 68760. physician Physician/Medical the as the attending IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe Torta Hylenteuson certificate 1. TYes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 2 (2No 1 ☐ Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 UNatural 5 Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft e Funeral Di etely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. the within To the 29b. Signature and title of certifier 29c. Lîcense number 29d. Date signed (Month. Day, Year) 00 30. Name and address of person who comple qd cause of death (Item 23a) (Type, Print) DAITINO1870 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

09-01325 Bobby Benbow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 05161

		1- For State Registrar	Oldi	e or maryland /			f Death	10 111011	car riys	_	eg. No.		2 0010
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Physician			ne disease, or con nly one cause on	mplications that caused the each line.	ie death. Do	not enter t	he mode of dyin	g, such as ca	ardiac or r	espiratory arre	st, shock, or hea	irt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause	1	a. Hypertensive Ath		otic Card	iovascular D	isease			_		Death
		or condition resulti		Due to (or as a conseq	uence of):								
-7	ē	Sequentially list co if any, leading to in	nmediate	Due to (or as a conseq	uence of):								
	Examiner	cause. Enter Unde (Disease or injury t	that initiated	c. Due to (or as a conseq									
ited d ansit		events resulting in	,	d.	derice or).								
760, icate be executed physician and the burial - transit	Medical	UNPENDED	,	AMENDED									
60, ate be	Med	IF FEMALE:		23c. If yes, outcome	of pregnan	псу					23d. Date of	delivery	
687 ertific ding p	sician/	23b. Was decedent past 12 months		1 Live birth		-	etal death 3	Ectopic	pregnanc	У	Month	D	ay Year
Box 687 e death certific the attending ed for use as t	/sic	1 Yes 2 1	No 9 Unkno	wn 9 Unknown	ne or death	5 O	her (Specify)						
P.O. Bcs that the desired by the second detached for	Phy	Part II. Other signi	ificant condition	h-ma-d	out not resu	Iting in the	underlying cause	given in Par	rt I.	23e. Did to	acco use contrib	oute to t	ne cause of death?
ords, P.O. w requires that the as been signed by should be detach	1 by									1 Yes	2 No 3	Proba	ably 4 Unknown
ds, requir	Completed									24a. Was a			opsy findings available
e law e has l	ш						•			autops	ned? de	eath?	mpletion of cause of
Re ifficat or, pag		25. Was case refer	red to medical	ī		-	26 Plac	ce of Death (Check on		No 1	Yes	2 No
Vital Rec ysiciau: The I his certificate I director, page	Be	examiner?		Hospital: 1 Inpatient	2 ER	R/Outpatient		Othor	Nursing I		Residence 6	Other:	Scene
of Vital Recoling Physician: The law After this certificate has funeral director, page 2 si	-: To	1 ✓ Yes 27. Manner of Deat	2 No th	28a. Date of Injury	28	b. Time of I		ury at Work?			ow injury occurre	_	
On endin sath. or: A	ţi	1 V Natural	5 Pending		"		1	Yes 2	No				
Division of Vital Records, tal or Attending Physician: The law requirers after death. "I Director: After this certificate has been siled in by the funeral director, page 2 should the company of the funeral director, page 2 should the funeral director.	ifica	2 Accident 3 Suicide	Investigation 6 Could not	28e Place of Injur	y - At home	e, farm, stre	et, factory, office	building, etc	c. 28			r or Rur	al Route Number, City
Division pital or Attent ours after death ceral Director:	Certification	4 Homicide	determin							or Town, St	ate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		29a. Certifier 1 (Check only one) 2		ician: To the best of my ler:On the basis of exami									
To the within To the comp	Medical	29b. Signature and		and manner stated.				se number	- an ou at I	unio, uate a	29d. Date signe		
	-	10	0	1.				.M.E.	OCM	te I	February 19	,	
		30 Name and add	lu MA	o completed cause of dea	th from 22	u.d.				-		,	
5 V			1. King, Jr., M			- /	111 Penn S	treet, Balt	timore,	MD 21201			
/	ate	31. Date filed (Moni		32. Registrar's									
Regist		900	ED 0 0 91	000 12	8	the ac	10.19						

			For State Registrar	State	of Maryla		artment of F rtificate of a		l Mental Hy	/gien Reg. N	711119	05162
	Physicia	an	1. Decedent's Name (First, M						2. Date of D Month FEBRUAF	D	ay Year .6. 2009	3. Time of Death
and the second	/Medic Examin		Blanche Leor 4a. Facility Name (If not insti Saint Jos	tution, give street and	number)	nter	4b. City, Town, o		ath		c. County of Death	
	Funeral Director		5. Social Security Number 217-18-4745	6. Sex 1 □ M 2 🔏	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, E	irth Day, Year 30/1	r) Cou	place (State or Foreign ntry)
	land ow		Usual Residence of Deceder 10a. State 10b. Co		10c.	City, Town or Lo	cation					10d. Inside City Limits
	e Mary	ctor	MD Ba	ltimore	I	undalk						1 ☐ Yes 2 No
	/ith the	Funeral Director	10e. Street and Number				10f. Zip Code				itizen of What Cou	intry?
	eath v	eral	7500 School 11. Marital Status	12. Was D	ecedent Ever in	U.S. 13.	21222 Was Decedent of H If Yes, specify Cubi	Hispanic Origin?	(Specify Yes or N	US	14. Race - Amer	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Item 12 to mit at most be notified at once.	þ	1 Never Married 2 3 Widowed 4 Divo	Married 1 TY	Forces? es 2/10/No Give or Dates:	i	If Yes, specify Cuba 1 □ Yes 2 🛣 No	an, Mexican, Pu	erto Rican, etc.)		Black, White, Specify: Whi	
21215-0036	72 ho natur	Completed	15. Dec (Specify only h	edent's Education nighest grade complete	ed)	I (Give	dent's Usual Occup kind of work done	during most of w	orking	111	Kind of Business/li	
121	within ene.	Jdmc	Elementary/Secondary (0-	12) Colleg	e (1-4or 5+)		DO NOT use retired	ு achinist	t .	We	estern El	ectric
d 2	il Hygi other	Be Co	12 17. Father's Name (First, Mid	ddle, Last)		11001		18. Mother's N	ame (First, Middl	e, Maide	en Surname)	
ylan	Menta Menta arked atic ev	일	Jacob Brid	ges				Pearl	Unk			
Maryland	12 sho h and 7 Is m		19a. Informant's Name/Rela Carole Burto				ng Address <i>(Street</i> 1 S. 48th				or Town, State, Z	ip Code)
e,	1 and Healt tem 2	0 9	20a. Method of Disposition	n/ Daugnter	201		osition (Name of matory or other place		Date	20c.	Location - City or T	own, State
m O	Pages nent of int: If I		1 Burial 2		om State		Cemetery	!	Feb 19 2009		sex, Mary	land
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Se	rvice Licensee	Mory	43 2	2. Name and Addre Cremation 8717 Gree	and Fune				aryland 21286
			23a. Part 1. Enter the disease shock, or heart failure.	se, or complications the	at caused the de	eath. Do not en					etalan seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka seeka s	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	cl.			RT FAIL	URE				
	/Medical Examiner		continued the second		to (or as a cons		OMYOPAT	HY			1	
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a cons							
	ecuted and transit	Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
38760,	ficate be executed physician and s the burial-transit	dical E	, copining in dealin, 220	d	e to (or as a cons	sequence or).						
Box 68	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 pronths?	³¹ 1 □ L	, outcome of pre ive birth 2□F	etal death 3	☐ Ectopic pregnan	су			23d. Date of deli	very Day Year
o	the deay y the a	ysic	1 □Yes 2 No 9 □ Unknown	1 701	Pregnant at time Jnknown	of death 51	Other (specify) _					
rds, P.	juires that the de n signed by the a lid be detached f	5	Part II. Other significant co	nditions contributing	to death but not	resulting in the u	underlying cause gi	ven in Part I.			2. 6	the cause of death?
Records,	ding Physiclan; The law requires that the death certif. h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Completed	<u> </u>						24a. Wa auf pei 1 ∐Yes	opsy formed	prior to death?	topsy findings available completion of cause of
of Vital	ctor, p	BeC	25. Was case referred to me examiner?				Tau		Death (Check only			
of \	Physic this c al dire		1 ☐ Yes 2 No 27. Manner of Death		1 Inpatient 2 Date of Injury	2 ER/Outpatie	int 3 🗆 DOA				6 ☐Other (Specially occurred	cify)
lon	fing After fune	ation	1 X Natural 5 □ F	Pending (Month, Day, Year	r) Injury	Wo	rk? ∐Yes 2 ∐No	200. Describ	C 11044 III	jury cocurred	
Division	al or Attendi after death. I Director: A d in by the fu	Certification: To	3 □ Suicide 6 □ C	could not be etermined 28e. P	lace of Injury - A pullding, etc. (Sp	at home, farm, st ecify)	reet, factory, office		28f. Location City or 7		and Number or Ru ate)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Ce (Check only 2 Me	rtifylng Physician: To dical Examiner: On t and	o the best of my the basis of exan manner stated.	knowledge, dea nination and/or i	th occurred at the nvestigation, in my	time, date and pl opinion, death o	lace, and due to the courred at the time	he cause e, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of	ertifier	,		29c. Licen	se number		29d. I	Date signed (Month	n, Day, Year)
			, (New	~/			254			2/17/0	T
)			30. Name and address of p	erson who completed		Item 23a) (Type	, Print)	eligion with a			e and a more of	
	St	ate	31. Date filed (Month, Day,	Year)	7 6 7 1 2. Registrar's Si	gnature /	DRIVE	TOWSO	IN, MARYL	_ANI	21204	
	Regist		EFR2	0.2009	serias 1	A. par	Re					

			1 - State of Maryland State of Maryland		artment of H			giene Reg. No. 20	09 05163
	byojoj	an.	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		3. Time of Death
	hysici: Medic/		Robert F. Bettien				02	16 20	09 5.25 PM
E	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	-	4c. County of	of Death
 E.	ıneral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	Birthplace (State or Foreign
	rector		214-12-9735 12€M 2□ F 91	Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	Country)
pu	>		Usual Residence of Decedent 10a. State 10b. County 10c, City.	Ŧ			00/1	.0/131/	
faryla	shor	ō		Town or Lo					10d. Inside City Limits 1 □Yes 2 No
the N	28a-1	Director	MD Baltimore Gle	en Arm	10f. Zip Code			10g. Citizen of W	
death with the Maryland	3a or	E D	11630 Glen Arm Rd. Apt. 303		21057			USA	nat Country:
deat	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No	- 14. Race	- American Indian,
-UU36 hours after	or it	by Fu	1 ☐ Yes 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		Tes, specify colour	Specify:	riican, etc.)	Specify:	, White, etc.
Z15-0036 thin 72 hours aft e.	tural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a Dooos	lent's Usual Occupa	tion			White
C13	n "na Medic	plet	(Specify only highest grade completed)	(Give	kind of work done du OO NOT use retired)	urina most of work	ring	16b. Kind of Bus	L. Martin
a z I z I 5- filed within 72 Hygiene.	er tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Asse	mbler				
// And be file Mental Hy	marked other than "natural", or items 23a or 28a-f show imatic event, It a Modical Examinact unat be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)
y iould	narke natic	욘	Richard Bettien				Conlon		
Ma d 2 st lth an	27 Is r traur		19a. Informant's Name/Relationship (Type. Print) Daniel Carney/Nephew		g Address (Street a. Hargrove				
s 1 an f Hea	item other		20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of	1	Date		City or Town, State
altimo rmit. Pages partment of	int: If		1 🗆 Buriai 2 acremation 3 🗀 Hemoval from State		natory`or other place ake Cremat	' i	Feb 19	Beltsvi	lle, Maryland
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta	Importa any Inju once.		21. Signature of Funeral Service Licensee	13 22	. Name and Address	s of Facility	700		, marjama
മ ഉമ	트등당		Lynda Sue Kitter		Cremation : 8717 Green	Pastures	Drive	Baltimore	, Maryland 21286
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart fallure. List only one cause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	00	rneu	mor	ua		Criset and Death
	niner		Due to for as a conseque	ence of):					
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a double act.)	тое ођ.					
ecuted	ind transi	Examiner	Cause (Disease or injury that initiated events						
cate be executed	cian a	E E	resulting in death) Last Due to (or as a conseque	ence of):					
ficate	I physician and s the burial-transit	edical	d			<u>.</u>			
h certi	attending p for use as	Z/ME	IF FEMALE: 23c. If yes, outcome of pregnant					23d Date	of delivery
death	e atte	sician/M	in the past 12 months? 1		Ectopic pregnancy Other <i>(specify)</i>			Mont	,
at the	should be detached	Phys	9 ☐ Unknown				1		
Olds, requires th	signed be de	₫	Part II. Other significant conditions contributing to death but not result	ting in the un	derlying cause giver	n in Part I.			oute to the cause of death?
nber /	should	eted	Marie Court, Crist						Probably 1 Unknown
he law		Completed					24a. Was a autop perfor	sv pri	ere autopsy findings available or to completion of cause of ath?
an: T	r this certificate ha		25. Was case referred to medical			26. Place of Deat	1 □ Yes	2 V 2 No 1	☐Yes 2V☐No
nysici	direct	To Be	examiner?	R/Outpatien	Othor			lence 6 ☐ Other	(Specify)
	iner tr	Lino		28b. Time of Injury	28c. Injury Work?	at		ow injury occurred	
ttendi leath.	tor: A	cati	2 Accident investigation		M 1 □ Ye	es 2□No			
or All	Unec in by	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
the Hospital or Attending Physician: The law requires that the death certificate hours district clearly.	o the Funeral Director: After the completely filled in by the funeral		29a. Certifier (Check only (C	ledge, death	occurred at the time	e, date and place,	and due to the	cause(s) and man	ner as stated.
n 24 h	pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death occur	red at the time, o	date and place, an	d due to the cause(s)
Vith t	Com	Σ	29b. Signature and title of certifier		29c. License				Month, Day, Year)
			10100		646	143	(02-18	-2009
			30. Name and address of person who completed cause of death (item, 3	23a) (Type, F	Print)	of an	Itiman	10 11	-2009 ID 21201
	Stat	te	31. Date fied (Month, Day, Year) 32. Registrar's Signatu	re	v sunce	a, ou	W.TVW	rue, 10	a a laul
R	Registra		FEB 2 0 2009 Decen 1	9. Spe	aked				

			1- State of Maryland / Dep	partment of Health and ertificate of Death	, ,	ene a. 2009 05164
	Physici		1. Decedent's Name (First, Middle, Last) HELEN BROWN		2. Date of Death Month	
-	/Medio		4a. Facility Name (If not institution, give street and number) Keswick Multi-Care Center	4b. City, Town, or Location of Dea		4c. County of Death
18. 11.	Funeral Director		5. Social Security Number 216-16-1483 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthda 85 Yrs.	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		year) 9. Birthplace (State or Foreign Country) White
	Maryland f show led at	tor	Usual Residence of Decedent	Location		10d. Inside City Limits 1 [X2Yes 2 □ No
	3a or 28a- st be notif	al Director	10e. Street and Number 3632 PArkdale Avenue	10f. Zip Code 21211	10	g. Citizen of What Country?
9000	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	d by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 h giene. er than "natu the Medica	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of w . DO NOT use retired) omemaker	rorking 1	6b. Kind of Business/Industry Own home
Maryland	2 should be filed and Mental Hygis Is marked other aumatic event, II	To Be (17. Father's Name (First, Middle, Last) Owen Lee Preston		ame (First, Middle, Ma Ruth Bu	,
ž	es 1 and 2 should of Health and Mer Item 27 Is marke r other traumatic		Robert Brown /son 18	iling Address (Street and Number or 1	t Edgewo	od MD 21040
Baltimore,	permit. Pages 1 Department of H. Important: If Iter any Injury or oth		cemetery, ci	position (Name of rematory or other place) W Crematory 2/		Oc. Location - City or Town, State Baltimore MD
Balt	permit. Departimont any Inj		21. Signature of Funeral Sorvice Licensee	Connelly Fun	eral Hom	Ave, Balto. MD e of Essex 21221
San L	Physician		23a. Part. Enter the disease, or conditions that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		ac or respiratory arres	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, it is a property for a superior of the conditions of the			Unknown
P.O. Box 6	the death certifi y the attending ched for use as	Physician/Mec		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that s been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Division or Vital Records,	The law ate has b page 2 si	Completed			24a. Was an autopsy performe 1⊡ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
<u> </u>	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other:	eath (Check only one)	
0	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	nce 6 Other (Specify) v injury occurred
visior	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	↑ Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town,	eet and Number or Rural Route Number,
Ŏ	oltal or Aurs after sral Directiled in by				illi	
	e Hospital 24 hours a e Funeral (letely filled	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, de (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla Investigation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	7			D0059056		2/17/09
	i		30. Name and address of person who completed cause of death (Item 23a) (Type Dalin + Salvic Me 3612 Falls N		211	
	Sta Registi	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	barles	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05165 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BROOKS Day **Physician** 07:20AM ELIZABETH 18,2009 FEBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2X ☐ F Months 90 Director 217-09-1932 8/4/1918 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show other traumatic event, the Medical Evaminer must be notified at ty⊈Yes 2 ☐ No Funeral Director WESTMINSTER CARROLL MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 205 ST. MARK WAY, APT. 506 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOUSEWIFE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental GUTHRIE ELEANOR MATTHEWS JOHN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2, 1, 1, 5, 8 19a. Informant's Name/Relationship (Type. Print) of Health an 205 ST. MARK WAY, APT. 506, WESTMINSTER, MD NORMAN E. BROOKS -HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY MEM. GARDENS 2/20/09 TIMONIUM, MD 5 ☐ Other (Specify) Signatural Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPTIC Immediate Cause (Final SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ABDOMINAL VISCUS HospItal or Attending Physician: The law requires that the death certificate be executed PERFORATED Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 X No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2. 29b. Signature and title of certifier Heloy M. D. DO017695 FEBRUARY 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 ABDALLAH J. HELOU, M.D. 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Theodore Ross Branthover February 16, 2009 8:07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville <u>7033 Sulky Lane</u> Montgomery 8. Date of Birth (Month, Day, March 19, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1⊠ M 2□ F 577-20-4108 86 Massachusetts Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7033 Sulky Lane 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Insurance Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levi Branthover Wilhemenia Bahra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna M. Branthover/Spouse 7033 Sulky Lane, Rockville, Maryland 20852 February 18, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/ Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Acute Myeloid Leukemia 14 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly g Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death.

I Director: A in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057805 February 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hetty Carraway, 1650 Orleans Street, Baltimore, Maryland 21205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Edna Clara Beeman February 14. 2009 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
er 1 Year | If Under 24 Hrs. 1008 W. Cross Street n/a 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🗷 F Director 1/14/36 Maryland 214-34-9286 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Experiment be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1° √Yes 2 No Director Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 W. Cross Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Russell Stallings Lena Harden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall Beeman / Husband 1008 W. Cross Street Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/18/09 Baltimore, Maryland Loudon Park Cemetery : 21. Signature of Funeral Service License 22. Name and Address of Facility LOudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that ceused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or as consequence of): Examiner metustatic Ovar icen if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □Yes 2 ☑No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1/□Yes 2 ☑ No 24a. Was an certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 40 Spice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Khandilus /mm D0052490 Feb 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001, S. Hynovy St. By Itimore MD 21225 Anita Khandelwal MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar (Basselle

09-01358 Gabriella Camejo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 05168

			1- For State Registrar			Cert	tificate of	Death			F	Reg. No.	_ 0 0	2 0010
Ph	ysicia		1. Decedent's Name (First, Midd	le,Last)					1.7		2. Date of De		/oor	3. Time of Death
ledical E	xami	ner	Gabriella Gise	11e Cam	ejo						Month February	15, 2009 Y	/ear	2315 hrs
			4a. Facility Name (if not institution University Hospital	on, give street ar	nd number)	4	b. City, Town, Baltimore		of Death		4c. Count	ty of Death a	
Fur	neral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. la:	st birthday)	If Under 1 Y			8. Date of B	irth (MM/DD/YY	YY) 9. Birti	hplace (State or Foreig
Dire	ctor		554-97-4071	1 M 2 X	F	22	Yrs.		ays Hou	irs Min.	01/11	/87	Ca	lifornia
	ny		Usual Residence of Decedent 10a. State 10b. County			10c. City, 7	Town or Location	on				VI	I	10d. Inside City Limits
land	28a-f show any-	tor		itura		Sa	nta Ro	_						1 Yes 2 X No
the Mary	23a or 28a-f sho notified at once.	Dire	10e. Street and Number 2851 Las Brisa	s Dr.				10f. Zip Code 93012				10g. Citizen of United		•
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safte	ral",	þ		vorced If Yes, Giv or Dates:				Yes 2 X				Specif		nite
hour	Exan	pe.	15. Decedent's Education (Spe				16a. Decedent during mo	st of working				16b. Kind of	Business/ii	naustry ,
21215-0036 Juld be filed within 72 Mental Hyoiene	other than "natura the Medical Exam of	Completed	Elementary/Secondary (0-12)	1	ge (1-4 or 4	5+)	st	udent				educat	ional	linstituti
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Fe lan	fite er tr		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Remo	val from St		lace of Disposi rematory or oth		cemetery,		Date	20c. Locatio	on - City or	Town, State
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m Pa	E.E.		John O. Mite	ltimor	al Home e, MD	21212	•							
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	ding e as t		23b. Was decedent pregnant in t past 12 months?	- ' <u>-</u> '	ive birth			al death	3 Ecto	pic pregnar	ісу	Month	n D	Day Year
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he de	y the		Part II. Other significant condi	9 0	Jnknown	th hut not ro	culting in the u	ndodvina caus	o given in	Port I	23e Did	tobacco use co	intribute to	the cause of death?
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F. 3	E 8	Me	29b. Signature and title of certifi		stated			29c. Lice	ense numb	er		29d. Date s	igned (Mor	nth, Day, Year)
			Vall 6	(_/	n	-D		0.	C.M.E.			February	16, 200	9
		-	30. Name and address of persor	who combleted	cause of	death (Item 1	23a)					1	-	
))			Russell Alexander MI			cal Exam		Penn Stre	et, Baltir	nore, MD	21201			
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Medical Examiner	3	Donald		arter			4b. City, Tow	o or Lo	cation of D		ebruary 11		y of Death			-
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Division tal or Attendi rs after death.	Certification:	3 Suicide	6 Could r	lot be	of Injury - At	nome, iami,	Street, ractory	y, Omoo	o amamy, a		or Town,	State)				
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h			lexander MD.	Assistant Me	edical Exa	aminer	111 Penn	Street	t, Baltim	ore, MI	21201					
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be executed Box 68760, P.O. Division of Vital Records, After t

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb. Day **Physician** 3:10 19, Cirincione Jennie 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford BelAir Lorien Rehabilitation Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Maryland 1 ☐ M 2 🖫 F 215-03-8353 6-18-1918 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Madical Examinar must be notified at 1 □Yes 2 No Director BelAir Harford Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 3 21009 1909 Emmorton RoaD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>۾</u> Specify: White 3 ➡Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Shrine of Little Fl. Housekeeper 7th Health and Mental Hygiden is m 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Culotta Concetta Farace Samuel ပ္ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Cirincioni 3719 Raspe Avenue Baltimore, Maryland 21224 Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 2-23-2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $\,$ Joseph $\,$ N $_{\bullet}$ 21. Signature of Funeral Service Licensee 263 South Conkling St. Baltimore, Md21224 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Immediate Cause (Final ALZHEIMER'S ENDSTAGE **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours area ...

To the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No hours after death. investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

Amend #31 perDVR g888 2/20/09 TT Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Barbara Cook Jean February 15,2009 4:10 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2011 Kelmore Road Dunda1k Baltimore Co. 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Nov. 22,1949 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2XXF Months Deys Hours 59 215-54-0622 Yrs. Delaware Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2011 Kelmore Road Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: Vietnam δ 1 ☐Yes 2 ☑ No 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Years Trucking Industry Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Cook Betty Rudolph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Harbor Road Apt. 1 Chesapeake Beach, MD 20732 Mrs. Serena Hight (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 2/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee Duda-Ruck Fufferal Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 But 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faile. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ·MYOCARDIAL INFARCTION ACUTE DAY resulting in death) Due to (or as a consequence of): WEEK ORONARY HRTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): YEARS Exami HYPERLIPIDEMIA Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ HYPOTHYROIDISM Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 **X** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 ☐ Yes 210 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O.

attending signed by the detach has been si e 2 should b page certificate After or Attending nours after death.

neral Director: Af
y filled in by the fur Hospital

Be

Certification: To

Medical

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

O

Funeral

Director

if than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be of Health and Menta item 27 is marked rother traumatic er

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

Physician

/Medical

physician and the burial-transit

as

nse

Examiner

within 24 hours a To the Funeral D completely

State Registrar and manner stated TIL

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 6 200 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 207

Year)

32. Registrar's Signature FEB20

AUE. DUNDAIK Md 21222 W156

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 9:05 AM Mary Bassford Culn February /Medical 19. 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Hours 219-28-2894 89 Yrs. Director Mary Land Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5113 Pembroke Avenue Funeral U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>م</u> 1 ☐ Yes 2 ☑ No Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental Jacob Prunn ္က Sophia Martens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Mr. Garland B. Bassford, III - Son 140 Springside Drive Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 02-21-2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Menes Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Complications /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours attendeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> brillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Artery dise me 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Artery disease Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospick 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred DCCSible BLACKOUT Sell to Floor in Kitchen 1 Natural 5 Pending 2 Accident Investigation JANUMY 23,2009 MorningM 1 □ Yes 2 🗹 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide Home 5113 Pein brooke Avenue, Balto, Mil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Amo

and

6701

32. Registrar's Signature

29c. License number

Al. Charles St. falto. Md 21 20%

29d. Date signed (Month, Day, Year) February 19, 2009

			1 For State Registrar	State of Ma	arylar		artmen rtificat			and M	lental Hy	giene Reg. N	09	05173
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle,	NOCE McCu	BBIN	CARE	1	Town, or	Location o	of Death	2. Date of De Month	Day 19	Year 09 nty of Death	3. Time of Death
	Funeral Director	爱.	5. Social Security Number 202-01-4213		e (la yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bir	th Y 14921	9. Birth	place (State or Foreign
	e Maryland 3a-f show tified at	Director	Usual Residence of Decedent 10a. State MD 10b. County			ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 24 oust be no	eral Dire	10e. Street and Number 6211 Falls Road					209				10g. Citizen d USA	f What Cou	ntry?
9003	d within 72 hours after death with the Maryland glene. If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		A	1 □ Yes 2	2 X No	Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	Spec	ace - Ameri lack, White, hify: Whi	etc. te
Maryland 21215-0036	within iene. than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4055	†)	16a. Deced (Give life, l Engi	kind of wor DO NOT us	rk done of	ation furing most)	of workii	ng	16b. Kind of Aviat	Business/In 1 O N	dustry
ryland	be od o	To Be	17. Father's Name (First, Middle, La Julian D'Arcy Ca	erey		10h Mailin	an Addana	(0)	Grac	e A. ———	McCubb:			
	1 and 2 Health a em 27 is ther tra		19a Informant's Name/Relationship Janet Cohen/Daug		20b. F	Place of Dispo	sition (Nam	ne of			revenso	er, City or Town, MD 2		
Baltimore,	nit. Page artment c ortant: If Injury or		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie	cify)	Ch	cemetery, crentes apea	ke Cr	emat	ory I	nc.		Beltsv		Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conditions the condition resulting in death)	omplications that caused ly one cause on each lin a. Due to (or as a	the death	h. Do not ente							re, Mai	Approximate Interval Between Onset and Death
38760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate frame from the country that initiated events resulting in death) Last	cDue to (or as a										
P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗀 Feta	I death 3□	Ectopic pre Other (spe						ate of delive	ery Day Year
Records, P	v requires that been signed b should be deta	þ	Parking sonism							lizerse	1 🗆 Y	es 2 No	3 Prob	ne cause of death?
ital Re	sician: The law certificate has b irector, page 2 si	Be Completed	25. Was case referred to medical examiner?						26. Place	of Death	24a. Was a autop performant 1 Yes	med? 2 No	prior to cor death?	psy findings available mpletion of cause of
Division or Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To E	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day)	y	ER/Outpatient 28b. Time of Injury		Other Bc. Injury Work	4 □ Nur	sing Hom	e 5 Resid	ence 6 🗆 Ot ow injury occu		y)
Divi	ospital or At hours after d ineral Direct y filled in by	al Certifi	4 Homicide determine	building, etc.	(Specify	v)	OCCURTED S	at the time	e, date and	I place a	City or Tow	n, State)		l Route Number,
	ro the Ho within 24) Го the Fu	Medical	(Check only one) 2 Medical Ex	aminer: On the basis of and manner stat	examınaı	tion and/or inv	estigation,	in my op License	inion, deat	h occurre	d at the time,	date and place	, and due to	the cause(s)
			30. Name and address of person wh	o completed cause of de-	ath (Item	23a) (Type 5	Print\	D	७० इप	717		,	9/09	,
	Sta	_	Rance Melan, 31. Date filed (Month, Day, Year)			ture		470	Lui	therv	ik, MD	2109	3	
	Registr	ar	EED 0 0 2000	Museum B	1. 1	acker								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Physician Dorothy Grace Catling February 2009 7:33 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Rebecca House Potomac 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year
Months Days If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖺 F Months 579-32-5545 95 June 1, 1913 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Even from the rottle of any Injury or other traumatic event, the Model Even from the rottle of any Opice. 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9910 River Road 20854 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: Š 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stuart Ernest Catling Mary Ann Hyland Grace ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky C. Cockerill/P.O.A. 1514 Tuba Court, Vienna, VA 22182 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State February 19, Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814 R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01546 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia Bacterial Week /Medical Due to (or as a consequence of): Examiner Alzheimers Dementia Years Sequentially list conditions Due to for as a consequence of) that's leading to firm editional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? ð 2X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 24 No 1 🗆 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Group Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a within 24 hou

To the Fune

completely fil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D16479 February 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Thomas C. Havell 4201 Cathedral Avenue NW, Washington, D.C. 20016 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8:50 A M Rita J. Crocker February 16. 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery <u>307 Clagett Drive</u> 9. Birthplace (Sta Country) New York 8. Date of Birth (Month, Day, (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Vear) Hours Months Days 1 □ M 2 🕱 F June 26, 1927 096-20-1864 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Tryes 2 □ No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 307 Clagett Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Defense Intelligence Elementary/Secondary (0-12) College (1-4or 5+) Analyst Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cornelius Regan Lulu Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 263 VT Route 113, P.O. Box 2, Chelsea, VT 05038 Charles M. Crocker, Sr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 20. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

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e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, pa

To the Hospital of within 24 hours at To the Funeral D

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Certification: To

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Physician: The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

Physician

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filed withir Hygiene.

Pages 1 and 2 should I

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Department of Health at
Important: If Item 27 is
any injury or other trau

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Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Exami Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an autopsy performed 1∐Yes 2.2MiNo

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ZIW

6 ☐ Could not be

29c. License number D0064615

29d. Date signed (Month, Day, Year) February 19, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive, Rockville, Maryland 20850 Genevieve Wroblewski, M.D.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature arked FFR20

		4	For State Registrar		State of Ma	arylan		artment <i>rtificate</i>					giene Reg. No.	71111	9	05	176
		_	1. Decedent's Name	(First, Middle, La	ist)							Date of Dea	ath Day	Yea		3. Time of I	Death
	Physicia /Medic		Linwood (Coleman								bruar	y 17	7, 2009		7:46	AM
	Examin		4a. Facility Name (If	not institution, gi	ve street and number)			4b. City, To	own, or	Location	of Death		4c.	County of De			
			Stella N		C	o (In um	ast birthday)	If Under 1	Tim	onium If Under	1 24 Hrs. 8	Date of Birt	h	Balti	MO1	e (State or	Foreign
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a.	ours a	by	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates:			1 □ Yes 2	MINO	Specify:					lac.		
7:46 a.n 215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Modical Examinat must be notified at	Completed	(Specia	15. Decedent's E fy only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occup done o	ation during mos	st of working	- 4	16b. Ki	nd of Busines	s/Indu	stry	
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17, 1 Mary	shou and M s mai		19a. Informant's Na	me/Relationship			19b. Maili	ng Address ((Street					r Town, State	, Zip C	ode)	
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EBRUARY Baltimore,	ges 1 t of H If iter		20a. Method of Disp 1 ■ Burial 2 □		☐ Removal from State	20b. F	Place of Dispo emetery, cre	osition (Name matory or oth	e of her plac	e)	Date	•	20c. Lo	ocation - City	or tow	n, State	
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FEBRUARY Baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Fur	neral Service Lien	1/2	-1		2. Name and			Loud			uneral			
			23a. Part 1. Enter h	e disease, or cy	plications that caused	the deat	h. Do not en	ter the mode	i 」ke of dyin	ng, such as	ve. Ba s cardiac or re	espiratory a	rrest,	Maryla:	1	21229 approximate	
	Physician		shock, or hear Immediate Cause (F	t failure. List	y one cause on each li	ne.									ď	nterval Bety Onset and D	eath
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MAN.	deat death	sicia	in the past 12 r 1 ☐ Yes 2 ☐		4 ☐ Pregnant a			Other (spe		· y				Month	D	ay Y	ear
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	or Attending Physician: The law requires that the death cert itter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	þ	Part II. Other signifi	icant conditions	contributing to death t	at not res	uning in the t	indenying ca	use giv	ellillrait	1.		Yes 2			bly 4 💢 U	
LINWOOD Vital Record	v requ	Completed						-				24a. Was	an	24b. Were	autops	sy findings a	available
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Division	or At after d Direct in by	Certification:	4 ☐ Homicide	determine		tc. <i>(Speci</i>	ome, tarm, si	reet, tactory,	office		281	City or To	wn, State	nd Number or e)	nurai .	noute ivum	ber,
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	ie Hos n 24 h ie Fur	edical			aminer: On the basis of the ctital one of the content of the conte		ation and/or i	nvestigation,	, in my o	opinion, de	ath occurred	at the time,	date and	d place, and o	lue to t	he cause(s)
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	f /		30. Name and address	ess of person wh	o completed cause of	death (Iter	m 23a) (Type	, Print)	T								
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	Sta Registr			EDO O O		A A	1 1	arked									

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, OC. 20 9. Birthplace Country) If Under 1 **Funeral** 1 ☐ M 2 1 F 5 Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 V No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Whit 1 □Yes 2 WNo Saltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, It a Medical once. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business udminis: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) uaunha 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenset 16924 YORK Rd. ai monkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eagle tipe. Approximate Interval Between Onset and Death Immediate Cause (Final anis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-trans and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 No 1 🗆 Yes 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 □No 1 🗌 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 32. Registrar's Signature 31. Date filed (Month, Day) State park Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** codore Parec Dennis 10/13 PM 16 2005 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number **Funeral** 62-5586 12 M 2 F MARYLand Months Days Hours Min 55 Director 16 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Md **Parkville** Teres 2K No Ballimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Wellbridge DRIVE 2123 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: BLack 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, PO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ome Improvement ainter land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 99 Mental h and Menta ennis CARISTINE + AULGOD Theodore ၉ Maryl 19a. Informant's Name/Relationship (Type. Print) TRIEND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkarthe Mid Item 27 I Henderson Wellbridg e prive. Gernice 420 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Date permit. Pages 1
Department of I
Important: If Ite
any Injury or ot Balto. Md. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBULUS Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MI/ISAS Melse Politica Chapel D. C. 21. Signature Fineral Service Lice Baldo. Md. 21213 oadway Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure mediate suse (Final isease or condition resulting in death) List only one cause on each line **Physician** SEPTIC SHOC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1 □ Yes 2 **□** No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred or Attending Patter death.
I Director: After do in by the funera Division **U**Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO 02/16/2009 HI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-1 ANTA WASSEY 5601 LOCHRAVEN RLUD , MA BALT IHORE ,21239 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State acks Registrar

DHMH 17 Rev 1/2001

1007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month 8:15 A^M 16,2009 February Edward C. Doty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2418 Oak Manor Road Edgemere Baltimore Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 1 3 M 2 □ F Months Hours 65 212-42-9759 Yrs Director June 11,1943 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar runal be notified at Edgemere Directo MD Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? United States 21219 Funeral 2418 Oak Manor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tayes 2 □ No
If Yes, Give
Year or Dates: 1962-66 1 ☐ Never Married 2 🔀 Married 1 ☐Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Foreman Steel Industry 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucy B. Hunt Benjamin F. Doty, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2006 Indian Forcet Drive Edgemere, MD 21219 19a. Informant's Name/Relationship (Type. Print) Brother 2326 Lodge Forest Drive Edgemere, MD Health a permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr. Mr. Benjamin F. Doty, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2009 Bel Air, Maryland Bel Air Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, MD 21222 Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or hear failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final Myocardial Justavitro **Physician** 12 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Africo scherta Carcho Vascolar Diseas b. Hyruster SING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the detached 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 □ Yes 2 □ No 24a. Was an . Were autopsy findings available prior to completion of cause of death? certificate has page 2 s autopsy performe 1 □ Yes 2 🛂 No 1 ☐Yes 2 ☐ No After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Iniury To the Hospital or Auternation within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Konert

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

1 and 2

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

9 Carles

Point

MUMM

Rd. Bultimore

MD

212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Tolele

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth Roseanna Elgin 2009 February 6:45 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmead Retirement Community Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 216-03-3572 1 □ M 2 □ F Director 9/03/1916 Balt., Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Welfoxl Examinar must be political Maryland Baltimore 1 ☐ Yes 2KINo Director Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 13801 York Road 21030 of America Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ₹☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: White à Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be eq pinous Michael Leibfried ဂ္ <u>Gresella Fester</u> 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Mrs. Elizabeth L. Disney/dau. 8612 Spruce Run Court Ellicott City, Maryland 20b. Place of Disposition (Name of cemeter), crematory or other place)

LVans Funeral
Chapel Bel Air 20a. Method of Disposition 20c. Location - City or Town, State Date eb. 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee and Address of Facility UT Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Jivision of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 PNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a. Was an After this certificate 1 □Yes 2 🖂 No the uneral director, 25. Was case referred to fnedical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After the 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Months Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician RICHARD Month FIETSamAnni FREDERICK 02 16 2009 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howsten wouty SONERA Coronais INNUARO MOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F Director 185-20-8984 81 PA Jul 4, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ij ir than "natural", or items 23a or 28a-f show the Medical Examiner must be rediffed at 1 ☐ Yes 2 No Director MD **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane Apt. 9G16 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No ₫ Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any hijury or other traumatic event, If a Madica once. Elementary/Secondary (0-12) College (1-4or 5+) Printer **Govt. Printing Office** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Frederick Fleischmann Charlena Reynolds ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Fleischmann 4737 Bounty Ct. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Feb 21, 2009 □Donation 5 □Other (Spellty) Cranberry Twp., PA Sunset Hill Memorial ardens Signature of Fygeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mundulla MO053 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FATTLUIZE RUSP INLAZINA 1 WORK AWTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PMEUMON A Psounomonons 3 WEE145 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). physician and the burlal-transit Due to (or as a consequence of): Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> OSTRUCTIVE warne 1 No 3 Probably 4 Unknown Completed Cyconny Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ Mo 1 ☐depatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

The law requires that the death certificate be executed P.O. 1 Division of Vital Records, been si should b cate has b page 2 sl certificate l To the Hospital or Attending Physician: After this certification funeral director, p within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

State Registrar

U. NYANIOM 31. Date filed (Month, Day, Year)

10724 4TTLE PATURETT PARKEWMY MA 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D36974

29d. Date signed (Month, Day, Year)

02/18/2019

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			For State	State of Marylan		artment of H <i>rtificate of L</i>			giene Reg. No. 200	9 05183
	Dhynisi		Registrar 1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month	ath	3. Time of Death
	Physicia /Medic	al	4a. Facility Name (If not institution, give	Anna Theresa	Fico	4b City Town or	Location of Death	Februa		09 11:30 P.º
)	Examin Funeral Director	er	2901 Rocks Road 5. Social Security Number 6. Se 212 10 7811		las <i>t birthday)</i> Yrs.		rettsvill If Under 24 Hrs. Hours Min.	Le 8. Date of Bir (Month, Da 07/30/1	Harfo	
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Ba-f st	Director	Maryland Harfor	·d .	Jarret	tsville				1 □Yes 2X No
	3a or 2		10e. Street and Number 2901 Rocks Road			10f. Zip Code	1084		10g. Citizen of Wha	-
396	filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 No		ecify Yes or No Rican, etc.)	- 14. Race -	American Indian, White, etc.
2-0	"nature	eted	15. Decedent's Edi (Specify only highest grad		(Give)	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of work	ing	16b. Kind of Busin	ness/Industry
212	be filed within tal Hygiene.	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	1	shier			Depart	ment Store
and	d d d	Be	17. Father's Name (First, Middle, Last)	Peter Giza				e (First, Middle, ia Czaj	Maiden Surname) a	
Mary	ges 1 and 2 should I tof Health and Men If Item 27 Is marke or other traumatic	2	19a. Informant's Name/Relationship (7			ng Address (Street a			er, City or Town, Sta	ate, Zip Code) aryland 21084
altimore, Maryland 21215-0036	Pages 1 alment of Heanant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crei Ly Cros	osition (Name of matory or other place SS Cemete	e) ry 02/1	7/2009		e, Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Licen	Doridge					eral Serv timore, M	ice, P.A. Maryland 21225
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat one cause on each line. a. Due (r as a conseq	Mu				rrest, Mnar	Approximate Interval Between Onset and Death
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68760,	ificate be executed g physician and ts the burial-transit	cal Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a conseq	uence of):					
O. Box 68		Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of the g ☐ Unknown	Ideath 3	Ectopic pregnancy	у		23d. Date o	
σ.	uires that the de signed by the a d be detached to	by	9 ☐ Unknown Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t		ute to the cause of death? ☐ Probably 4 ☐ Unknown
Division of Vital Records,	The law requate has been bage 2 shoul	Completed						24a. Was	an 24b. We prior dea	re autopsy findings available or to completion of cause of th?
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	LEB/0.44:-	othe Othe	26. Place of Deat			_
n of	d ing Phy h. After this funeral d	n: To	27. Manner of Death 1 Natural 5 □ Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time o	IL 3 DOA	4 LI Nursing Ho		dence 6 ☐Other how injury occurred	(Specify)
Divisio	ten leat tor: the	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, str fy)	M 1 □¹	Yes 2□No	28f. Location (: City or To		or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier CertifyIng Physics (Check only one)	yslcian: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tin	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	ner as stated. If due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		N	29c. License	e number	+3	29d. Date signed (/	Month, Day, Year) 7 200 9
4	/		30. Name and address of person who d	completed cause of death (Iter	n 23a) (Type,	Print)	ERSt,	BALT	imort,	MP, 21225
	Sta Registr		31. Date filed (Month, Day_Year)	32 Registrar's Signa	ature.	a Kad	,		,	
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DHMH 17 Rev 1/2001

			For State Registrar	State of Mar		partmen <i>ertificat</i>				ene 2009	05184
			Decedent's Name (First, Middle, Last)					Date of Death Month		3. Time of Death
	Physicia /Medic		Evelyn Lo	ouise Fultz					Februar		4:33 P. M
	Examin	er	4a. Facility Name (If not institution, give			4b. City,		ation of Death		4c. County of Dea	
eri ⁱ			Gilchrist Hosp 5. Social Security Number 6. Se	·	In yrs. last birtho	av) If Under	Towson	1 Under 24 Hrs.	8. Date of Birth	Baltino 9. Bir	
	Funeral Director			□M ADF	93 Yrs	Months	Days H	ours Min.	(Month, Day, July 13	, 1915 Inc	thplace (State or Foreign puntry) liana
_	pu >		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town o	. Location					10d. Inside City Limits
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	the N	Director	10e, Street and Number			10f. Zip	Code		10	g. Citizen of What Co	ountry?
	h with	al D	301 Charles ST. A	Ave. Apt.D		21	204			"United St of Ameri	
	r deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced	lent of Hispar	nic Origin? (Spe lexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	erican Indian,
20	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes		pecify:			hite
ş	2 hour		15. Decedent's Edi	ucation	16a. D	ecedent's Usua	al Occupation	1		16b. Kind of Business	/Industry
212	thin 7: ee. an "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(G			ng most of worki	ng	CC:	
7	ed wil lygien ner th	Con	Elementary/Secondary (0-12)			cleri	-		(First 86 1 H)	office	
and	be fill ed otl	Be	17. Father's Name (First, Middle, Last) Charles W.	Fears			18.		e A. Pay	faiden Surname)	
2	should nd Me mark imark	င္	19a. Informant's Name/Relationship (7		19b. M	lailing Address	(Street and			City or Town, State,	Zip Code)
Σ	alth a 27 is er trau		Mrs. Ginger M. P		1	-				D Towson,	
e,	es 1 a of He of He filtem		20a. Method of Disposition	Damaval from State	20b. Place of D	isposition (Nar crematory or o	ne of ther place)			20c. Location - City or	Town, State
Ĕ	Pag tment tant: I	l l	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Chape1	rematory or of Funeral Bel	ir	Febru 19,	2009	Forest Hil	.1, Maryland
Ra	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinar must be notified at once.	, 5	21. Signature of Funeral Service Licens	Bully		22. Name ar Peacefu 23	ıl Alte	Facility Ernative Ck Road	es Funera	al &Cremat um, Maryla	cion Ctr.,P.A
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	e death. Do not						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. BVY	7 · M	Anc	er				Months
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of)						
		řer	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of)	:					
	cuted or ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
Ď,	oe exe sian al urial-t		resulting in death) Last	Due to (or as a c	consequence of)						
9/8	icate be executed physician and s the burial-transit	dical		d							
Box	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of de	alivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at ti		3 ☐ Ectopic p 5 ☐ Other (sp				Month	Day Year
О	at the	phys	9 ☐ Unknown	9 ☐ Unknown							
Š	requires that the de neen signed by the a nould be detached	þ	Part II. Other significant conditions of	Intributing to death but i	not resulting in th	ne underlying c	ause given in	n Part I.			o the cause of death? Probably 4 ☐ Unknown
Š	requ	eted			<u>-</u>						
Records,	sician: The law certificate has b irector, page 2 sf	Completed							24a. Was ar autops perforn	y prior to ned2 death?	utopsy findings available completion of cause of
Vital	sician: T certificat rector, pa	Be Co	25. Was case referred to medical				26	Place of Deatl	1 ☐ Yes 2	2 □No 1 □Ye	s 2 No
⋝	Physici this cer al direc	70 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outp	atient 3 🗍 DO	Othor			ence 6 Other (Sp	ecity) + OSpice
n of	Attending Physician: r death. ector: After this certific by the funeral director, I	on:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Tin	ıry	8c. Injury at Work?		28d. Describe ho	w injury occurred	
Division	r Attend er death. rector: / by the f	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	I	/ - At home form	M street factor		2 🗆 No	28f Location (Ct	reet and Number or F	Pural Pauto Numbar
2	- 0 -	Certification:	4 Homicide determined	building, etc.	(Specify)	, street, lactory	, onice		City or Towr	n, State)	urar noute Number,
	To the Hospital or within 24 hours after To the Funeral Life completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge,	death occurred	at the time,	date and place,	and due to the c	ause(s) and manner	as stated.
	To the H within 24 To the F complete	Medical	one)	and manner state	ed.						
	5		29b. Signature and title of certifier	R.C.	, wo	290	c. License nu		2	9d. Date signed (Mor	18 2009
•			30. Name and address of person wh	mpleted cause of lea	ith (Item 23a) (Ti	/pe, Print)			,	- 37 M-1	,18,2009
_			WA. Riley	Garage	6701	N.Ch	arles-	St. Bal	to my	20204	li de la companya de la companya de la companya de la companya de la companya de la companya de la companya de
	Sta		31. Date filed (Morth, Day, Year)	32. Registrar	s Signature	barker	P				
	Registr	ar	FEB 2 0 20	109 Lance	~ N. 1	7					

4: 33 pm

			For	State of Mar	ryland	/ Depa	artment of	Hea	Ith and	Mental F	lygier	ne 200	1 Q	05	185
			State Registrar			Cei	rtificate o	f De	ath		Reg. I	Vo. 4 0 1	J)	00	103
:	Physicia	an	1. Decedent's Name (First, Middle, La Gaile P. Grothe	ist)						2. Date of Month 02-17	Death	Pay Y	'ear	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town	orLoc	ation of De			4c. County of	Death	0856	A M
	- Examin	er	Atlantic General				Berli:					Worch		er	
100:0826	Funeral Director			Sex 7. Age 1		st birthday) Yrs.	If Under 1 Yes Months Day		Under 24 H ours Mi		Birth Day, Yea -1936	ar) 9	Birthpl Coun		or Foreign
080	pu »		Usual Residence of Decedent 10a. State 10b. County		10a City	Town or Lo	nation						14.	Od Inside (C/A . I !!!-
A	laryla shov	ō	,	ester		shopv								0d. Inside 0	s 2⊠No
12	the N 28a-1	rect	10e. Street and Number	icscc1		SHOPV	10f. Zip Code	e			10a	Citizen of Wha	at Coun		
60	death with the Maryland rms 23a or 28a-f show rmst be notified of	Funeral Director	13117 Selby Rd				1 '	813			,	USA		,.	
10	death	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13.	Was Decedent of If Yes, specify Co	of Hispar	nic Origin?	(Specify Yes or	No-	14. Race -			
DoD:3/i- 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating must be notified at once.	ρ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:			1 □Yes 2 🛣 N		pecify:	erio riican, eic.;		Specify:	_{White, e} Whit		
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Dol 121	within ene. than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT use reti Manage					Food S	+		
ر م	filed Hygin	ပိ	17. Father's Name (First, Middle, Las	")		11550	• Hallage		Mother's N	lame (First, Mide				5	
125/3C Marylan	lid be fental rked c	To Be	Alvin Grothe					М	largar	et Mill	er				
25 Mary	shou and N s mai	_	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stre	et and l	Number or	Rural Route Nu	nber, Cit	y or Town, St	ate, Zip	Code)	
ŽΣ	and 2 ealth n 27 i		Carlyn K. Grothe	(Wife)			7 Selby		Bisho	pville,	MD	21813			
ore C	Jes 1 t of H lifiter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 E	Removal from State	20b. Pla	ice of Dispo netery, crer	sition (Name of natory or other p	olace)		Date	20c.	Location - Ci	ty or To	wn, State	
DOB.	tmeni tmeni tant: jury o		4 □ Donation 5 □ Other (Special		St.		ius Ceme			21-2009	Fo	rest H	i11,	MD	
DOB: 9	permit Depar Impor any In		21. Signature of Funeral Service Lice	Frac) @		nc. 610		L.	Schimune ail Rd	k Fu Bel	neral Air, M	Home D 2!	e of E 1014	3e1Air
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line	he death.	Do not ent	er the mode of o	dying, su	uch as card	liac or respirator	y arrest,			Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acu	the	Mys.	caroltu	1	Infan	chion			1	Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):	Caroltu Ostery	N	0.00	110				1/2	
		ē	Sequentially list conditions, if any leading to immediate	b Due to (or as a	onseque	ence of):	revy		isons	e	- Common			ye erre	ź
	uted	Examiner	Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	•	,.									
\~ O	ficate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):									
838	ficate be physicia s the bur	edical		d											
	ertific ling p	Med	IF FEMALE:												
30 - 5 .0. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal d	death 3	Ectopic pregna Other (specify)				-	23d. Date of Month			Year
ф.	s that ned b	by Pt	Part II. Other significant conditions	contributing to death but	not result	ing in the u	nderlying cause	given in	Part I.	23e. D	d tobacc	o use contribi	ute to th	e cause of	death?
る で	quire en sig	ed b	Hypurtens!	on ', H;	1801	lipid	emta			1	Yes	2 No 3	☐ Prob	ably 4□	Unknown
SS# 2 Record	The law requires ate has been sign age 2 should be	Completed	Peripheral And	very Dise ass	2 1	Pr	tax CV	A		pe	rformed	prio dea	or to con ath?	psy findings	available cause of
ital	iclan: The certificate rector, pag	Bec	25. Was case referred to medical					26.	Place of D	1 □Ye eath (Check on		NO I L	Yes	2 🗆 No	
~/=>	Physiclan: this certific al director,		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	t 2 🗆 E	R/Outpatie	nt 3 00A	Other: 4	I ☐ Nursing	Home 5□R	esidence	6 □Other	(Specify	()	
200	ilng Phys 1. After this funeral di	:io	27. Manor of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 2	8b. Time o Injury	N.	njury at Vork?		28d. Descrit	e how in	jury occurred			
, Gai	ttending death.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ne l					2 □No						
e, (or A after of Direction by	Certification: To	4 ☐ Homicide determined		y - At nom (Specify)	ie, tarm, str	eet, factory, offic	e		28f. Location	n (Street Town, St	and Number ate)	or Rural	Route Nur	mber,
主	spital ours neral filled	Č E	29a. Certifier 1 Certifying P	hysician: To the best of	mv knowl	ledge, deat	h occurred at the	e time. d	date and pla	ace and due to	he cause	e(s) and man	ner as si	tated	- 100
Grother	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis of e	examinatio	on and/or in	vestigation, in m	ny opinio	on, death oc	courred at the tin	ne, date a	and place, and	due to	the cause((s)
S)	To th within To th comp	ĭ	29b. Signature and title of certified	0 1	20		29c. Lice	ense nur	mber		29d. I	Date signed (Month, [Day, Year)	
			(Kmytan) di	Sound	NA	•		55	42	7	Fel	CHARY	17	1.20	109
/	ŕ		30. Name and address of person who	completed cause of dea	ath (Item 2	23a) (Type,	Print)		310	4 Frankli	n Av	4, B.	Lun	Many	Lind
0			31. Date filed (Month, Day, Year)	32, Registrar	Signature	Uman	na stead	ul	; 34	ith 30	1	121	811		
	Sta Registra		or. Date med (Motiti, Day, Tear)	32 Hegistrar	Sugnatu	re	Ked								
			FEB 2 1 70	39 Kallander Man	100	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 111

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	/Me	dica	
E	xan	nine	r

For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Madical Exploration Library and once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

al	Anna Gr	aybil	1		FEB. 9,	2009		1132	dM
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death		4c. Count	ty of Death		
	GOLDEN LIVING CENTER		FREDERICK			FREI	DERICK		
		s. last birthday)	If Under 1 Year	Under 24 Hrs.	8. Date of Birt	th .	9. Birthplac	e (State or	Foreign
	1 □ M 2 ▼ WF	Yrs.	Months Days I	Hours Min.	(Month, Da JUNE 10	y, rear) 1925	Country		D.4
	Usual Residence of Decedent				JOIL 10		SAFE HA	KBUK,	ZA
		City, Town or Loca	ation				10d	. Inside City	Limits
-	Tob. County	,,, , , , , , , , , , , , , , , , , ,							
양	MD FREDERICK M	IDDLETOWN						1 ☐ Yes	XX
ie	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country	/?	
	2527 QUEBEC SCHOOL RD.		21769	9		US/	4		
era	140 11/10 11/10	U.S. 13 W	as Decedent of Hisp.		ecify Yes or No		ace - American	Indian.	
ڃ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	If	Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)		ack, White, etc		
2	If Yes, Give	1	☐Yes 2√√√ No 3	Specify:		Spec	ify: WHITE	=	
D L		100				401 101-1-11	Davidson a florida		
ete	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation aind of work done duri		ing	10D. KING OF	Business/Indus	stry	
ď	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired)						
ē	12	HOMEMAK					NN HOME		
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	e (First, Middle,	Maiden Surna	ame)		
70 8	HARRY C. McCARDLE			KATIE K.	SHANK				
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street and			er. Citv or Tow	n. State. Zip C	ode)	
	C. HERBERT Graybill	1						,	
			uebec School		·			- Ct-t-	
	20a. Method of Disposition 20b	cemetery, crem	ition (Name of atory or other place)	-	Date	20C. Location	ı - City or Towi	i, State	
	4 □ Donation 5 □ Other (Specify) Mt	Hope UM C	Cemetery	Feb 13	3 , 2009	Drumore 1	Twp, PA		
	21. Si natura of Funeral Service Licen: ee	22.	Name and Address Fink Funera	of Facility	^				
						MD 210/	21		
	3 3		426 Crain Hy	· · · · · · · · · · · · · · · · · · ·		-		pproximate	
	23a. Part . Enter the disease, d. co oplications that caused the de shock or heart failure. List, in one cause on each line.	ath. Do not ente	er the mode of dying,	such as cardiac	or respiratory a	ilesi,	11	nterval Betwonset and D	/een
	Immediate use (Final disease or condition	amula o	Pathy					miset and D	Çaui
	resulting in death) Due to (or as a cons	equence on:	1 //						
		/-	/						
-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a constitution of the conditions)	equence of):							
Ē	cause. Enter Underlying Cause (Disease or injury						2.4		
Kan	that initiated events c	acuonos of):							
Ш	Due to (or as a cons	equence on.							
<u>8</u>	d								
hysician/Medical Examiner									
§	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. E	Date of delivery	/	
cia	in the past 12 months?		Ectopic pregnancy Other (specify)			1	Month D	ay Y	ear
ysi	1 Yes 2 No 9 Unknown 9 Unknown		(-,,,						
유	Part II. Other significant conditions contributing to death but not r	esulting in the un	derlying cause given	in Part I	23e. Did 1	tobacco use co	ontribute to the	cause of de	eath?
\$	Demen L'a	esaiting in the an	idenying addoc given	mi aici.			_		
Completed by	Jewith Ing.				1 🗆	Yes 2121VO	3∐ Proba	bly 4 □ u	пкломп
ĕ					24a. Was		b. Were autops	y findings a	vailable
Ę			_		auto perfe	ormed2/	prior to com death?		use of
ပိ					1 □ Yes	2-☑No	1 □Yes 2	□No	
Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only	one)			
ျ		☐ ER/Outpatien		4 Nursing H	ome 5 Res	idence 6 🗆 C	Other (Specify)		
Ë	27. Mannerof Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year,	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe	how injury occ	urred		
ıĕ	2 Accident investigation			s 2 □No					
Ę.	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	home, farm, stre	eet, factory, office			Street and Nui	mber or Rural	Route Numl	ber,
erti	4 Homicide determined building, etc. (Spe	есіту)			City or To	wn, State)			
0	29a. Certifier 1 Certifying Physician: To the best of my	rnowledge death	a occurred at the time	date and place	and due to the	cause(s) and	manner as sta	ted	
ica	(Check only 2 Medical Examiner: On the basis of exam								ı
Medical Certification: To	one) and manner stated.					001 5	and /44	01/ 1/ 1	
2	29b. Signature and title of certifier		29c. License r	number		_	ned (Month, D		3.0
ļ	1 / Le MI		DE	0417		Februa	ury 10	, 100	19
	30. Name and address of person who completed cause of death (I	tem 23a) (Tvne I		- 11/				217	2)
	140 - 01 - 01 - 01 - 0 - 0			W / A.	1.	Fred	denne	N M	12
		INOW	ias Tol	111500	DV.	TICA	10010	1	/)

State Registrar

			for State	State of N	Maryland / Dep	artment of l			711114	05187
			Registrar 1. Decedent's Name (First, Middle,	Last)		Timoate of	Death	2. Date of Death	g. No. L. O O J	3. Time of Death
	Physici	an	Janet Roseber	ŕ				Month	Day Year	
	/Medic		4a. Facility Name (If not institution,		ar)	4h City Town	or Location of Death	<u>February</u>	16, 2009 4c. County of Deat	13:35 P M
	Examin	er			,					
	Funeral		3441 South Leisu 5. Social Security Number 6	re World B	Soulevard 16/21 Age (In yrs. last birthday	It Under 1 Year		8. Date of Birth	Montgome 9. Birt	hplace (State or Foreign
	Director		361-14-9216	1□M 2፟AF	82 Yrs.	Months Days	Hours Min.	(Month, Day, February 22	Year) Co.	intry) inois
	σ		Usual Residence of Decedent					restairy 22	, 1020 111	111015
	rylan how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f s	턍	Maryland Montg	nmerv	Si	ver Spri	nø			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	ZMCI J		10f. Zip Code		10	g. Citizen of What Co	untry?
	th wi		3441 South Leisure	World Bou	levard #2B	209	06		United Sta	ates
	ems ems	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
98	or It	Ę	1 XXNever Married 2 ☐ Marrie			1 □Yes 2 No			Specify: Wh	
21215-0036	ural",	d by	3 Widowed 4 Divorced	Year or Date			, ,			
5	72 h "natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occu e kind of work done	pation during most of wor ed)	king	6b. Kind of Business/I	ndustry
121	vithin han han	ш	Elementary/Secondary (0-12)	College (1-4c	or 5+)				77	
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it in its deal Exam must be malled a	ပိ	17. Father's Name (First, Middle, La	et)	Admir	istrativ	e Assista	nt ne (First, Middle, M	Hospital	
and	ntal he fi	Be		51)						
Ž	should and Men s marke umatic	ပ္	Fred A. Gezel 19a. Informant's Name/Relationship	/T D	405 14-1	A .d.d /O4		Roseberry		T- 0: (1)
Maryland	d 2 st th an 7 is r traur		,	,		-			City or Town, State, Z	•
	1 and 2 Health item 27 item 27 is	1	Lawrence Peck / 20a. Method of Disposition	Friend	14910 20b. Place of Disp	Brownst	one Drive	, Burtons	sville, Man	yland 20866
آور	Pages nent of I int: If Ite iry or o		1 🖾 Burial 2 🗆 Cremation 3			matory or other pla lemorial	Park Febru	ary 20,	•	·
Ħπ	t. Partmen		4 □ Donation 5 □ Other (Spe	-	1		: 200	9 0	lney, Mary	1and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it in "infan Exanting in the Item In Item once.		21. Signature of Funeral Service Li	•	Ŗ	2. Name and Addr	Pumphrey	Funeral	Home/Rocky	ille. Inc.
	402 00	_	males						Home/Rockv kville, Mary	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caus ily one cause on each	sed the death. Do not er i line.	iter the mode of dy	ing, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	_a Stro	ke					Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					
	LXummor	Ļ	Sequentially list conditions,	b						
	red isit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Charles of highly that initiated events	Due to (or a	as a consequence of):					
	and I-tran	Examiner	that initiated events resulting in death) Last	CDue to (or:	as a consequence of):					
8760,	cate be executed physician and the burlal-transit	ᄪ								
387	icate phys	dical	`	d						
9 ×	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy					
Вох	atter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birtl	n 2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of deli Month	Day Year
Ö	the d	ysic	1 □Yes 2 2XNo 9 □ Unknown	9 Unknow		□ Other (specify) _				
σ.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w requires that s been signed I should be det	d by	Hypertension, b	east canc	er hvnerli	nidemia		1 □ Yes	s 2□No 3□Pr	obably 4 🔀 Unknown
Ö	v req	ete			J Myperan			24-11/	241 111	
Re	ne law s has ge 2 s	Completed						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
<u>_</u>	sician; The certificate h rector, page							1 □Yes 2	X No 1 □Yes	2 □ No
Vital	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	hor:	th (Check only one,		
of	Phys rthis raldi	F.	1 Yes 2 ♣No 27. Manner of Death	1 ∐ Inpa	atient 2 ER/Outpatie	JIL 3 L DOA	4 🗆 Nursing 🗖	lome 5 X Resider 28d. Describe how	nce 6 Other (Spec	cify)
on	ding Ph h. After th funeral	흲	1 Natural 5 ☐ Pending	(Month,	Day, Year) Injury	Wo	rk? ⊒Yes 2 ⊒No	20d. Describe nov	winjury occurred	
S	deat ctor: y the	ica	3 Suicide 6 Could no	be 280 Place of	lnjury - At home, farm, si		2103 2 110	28f Location (Stre	eet and Number or Ru	ral Route Number
Division	after after Dire	Certification: To	4 ☐ Homicide determin	building,	etc. (Specify)			City or Town,	State)	rai Proble Hamber,
_	spita ours neral		29a. Certifier 1 X Certifying	Physician: To the be	st of my knowledge, dea	th occurred at the	time, date and place	and due to the ca	use(s) and manner as	stated
	24 h 24 h e Fur letely	Medical			s of examination and/or i					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifie			29c. Licen	se number	29	d. Date signed (Month	ı, Day, Year)
	->-0		I muse			h	21340		02-18.	-09
	7		30. Name and address of person w	no completed cause of	f death (Item 23a) (Type	Print)	211		, 0	
20			Raymond Bass, M.			,	on Marri	and 20004	5	
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DHMH 17 Rev 1/2001

amend #3,17,18&19b PerPHY &FH G8893/13/09 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 16, 2009 **Physician** Larry Michael Greenberg 5:53 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventis Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 **⅓**M 2 ☐ F Months Days Hours Min 213-56-9220 Yrs Director 12/6/1947 DC 61 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its "Nectral Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD Montgomery North Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20878 USA 10542 Smithy Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: within 72 hours after 1X Never Married 2 ☐ Married Maryland 21215-0036 than "natural", or 1 □Yes 2 🛂No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Retail Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H Mowitz Movitz Celia Wilfred Greenberg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1240B Fingerboard Road, Ijamsville, MD 21754 Pages 1 and 2 ment of Health a ant: If item 27 Is Robert Ian Greenberg / Brother 10240B Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services vollall Po Box 14131, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Minutes Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical the as nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Day in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No P.0. 9 HInknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ! rmed? 2 **Z**No 2 No 1 ☐ Yes 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other; 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Injury 1 X Natural 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) February 16, 2009 DO068207 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Kella M.D. 9901 Medical Center Drive, Rockville, MD FEB 2 0 2009 32 Registrar's Signature 31. Date filed (Month, parker State le sur Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 19, 2009 **Physician** Frank Joseph Hamilton 10:22A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Min. December 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Illinois 336-26-1590 76 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r items 23a or 28a-f shov 1 √XYes 2 □ No Director Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 216 Cedarcroft Road 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1/2 Yes 2 Nd 57-162 1 Never Married 2 Married 1 □Yes 2**XX**No Baltimore, Maryland 21215-0036 ages 1 and 2 should be filed within 72 hours aft nt of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or or other traumatic event, I'm Medical Evan is or other traumatic event. Specify: White If Yes, Give Year or Dates: Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sales Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Guv Hamilton Alma Drier ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Davis Hamilton Wife 216 Cedarcroft Road Baltimore, Maryland 21212 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot GreenMount Crematory Feb 20, 2009 Baltimore, Maryland Donation 5 ☐ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Rus /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 6 ☑ Other (Sp 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md Zizak -Bm 6701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 JACK ANDERSON HOLZ February 18. 21:50 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson 8. Date of Birth (Month, Day, Year)
Sept. 17,1921 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 87 **Director** 233-16-3851 Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2√ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WW 11 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, the Park Elementary/Secondary (0-12) College (1-4or 5+) <u>Chemical Engineer</u> Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Edward Holz Nel1 Quesenberry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. P.O. Box 146751 Boston, MA. 02114 Barbara Manning Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-21-09 Springhill Cemetery Charleston, West Virginia 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** schemic yours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions ner if any loosing to in medicacuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe certificate 2 No 1 ☐ Yes 1 Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Wilpig 1 Tes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 6701

N Charles ST TONSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Registrar's Signatur

31. Date filed (Month, Day, Year)

2009

			1 - State of Maryland / Dep Registrar Ce	artment of Health and Ment ertificate of Death	tal Hygiene Reg. No. 2009 05191
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Catherine Patrice Howell		ate of Death Aonth Oruany 13 2009 7:45 P M
A A	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 6. Sex 1 M 2 M F 80 Yrs.	Months Dave Hours Min	4c. County of Death Frederick ate of Birth Month, Day, Year) rch 28, 1928 Property New York
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low Maryland Frederick Middlet	ocation COWN	10d. Inside City Limits 1
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventinal The notified at once.	Funeral	1 ☐ Never Married 2 ◯ Married 1 ☐ Yes 2 ◯ No If Yes, Give	10f. Zip Code 21769 Was Decedent of Hispanic Origin? (Specify \(\) If Yes, specify Cuban, Mexican, Puerlo Rican 1 □Yes 2⊠No Specify:	10g. Citizen of What Country? United States Yes or Non, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 hours giene. ir than "natural"; ire Mediel En	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ncial Aid Director	16b. Kind of Business/Industry Higher Education
Maryland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) James Mullen	18. Mother's Name (Firs Evelyn Fu	st, Middle, Maiden Surname) 1ry
, Mar	and 2 sho lealth and m 27 is mi her traumi		Dr. Edgar N. Howell / Husband 201	ing Address (Street and Number or Rural Roll Mariam Pass, Middleto	own, MD 21769
altimore,	t. Pages 1 tment of H tant: If ite jury or ot		4□Donation 5□Other (Specify) Memoria	naven 1 Gardens Feb. 16 2009	Frederick, Maryland
Ba	Dermi Depar Impo any ir			501 Catoctin Mtn. Hwy	vices, Skkot Cody P.A. y. Frederick, MD 21701
	Physician /Medical Examiner	iner	shock or heart failure. List only one cause on each line.	HEART DISEASE	Interval Between Onset and Death
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last c		
P.O. Box	at the death certifi by the attending tached for use as	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, F	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the to INCARCERATE D UMBILICAL HERN	green, and a second green are a second	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
Division of Vital Records,	yslcian: The law re is certificate has be director, page 2 sho	Completed	MELLITUS, ATRIAL FIB, SEIZE 25. Was case referred to medical	1	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No
n of Vii	rding Physicia th. : After this cert funeral directo	on: To Be	examiner? 1 Yes 2 No	of 28c. Injury at 28d. I Work?	5 Residence 6 Other (Specify) Describe how injury occurred
Divisio	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		ocation (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dii completely filled in	Medical	29a. Certifier (Check only one) 1		
	¥≥¥8) Done lom mo	021936	2/14/2009
(1) √ Sta	te_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	THOMAS JOHNSON DO	R, FREDERICK, MD 21702

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:00 p^M BERTHA HARRISON 2/16/2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 6407 Cabin Branch Court Capitol Heights Prince George's If Under 1 Year If Und 8. Date of Birth (Month, Day, Yea 7/29/1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖾 F 95 218-16-0192 Camden, Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprointer must be redified at 10a. State 1 TXYes 2 □ No Director Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6407 Cabin Branch Court 20743 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2₩ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Black δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied wit Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, It. 100c. Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aurelia Dye Willie Patterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Cabin Branch Ct. Capitol Heights, Maryland 2074 Antionette Matthews /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2009|Washington, DC Mt. Olivet Funera Service Licen 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a, Part 1/ Enter the disease, or complice shock, or heart failure. List on one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC ISCHEMIC HEART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burial Box 68760, Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) P.O. 9 Unknown 9 Dunknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t certificate i 1 ☐ Yes 2 No Physiclan: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death. 1 XNatural 5 Pending investigation Injury n 24 hours after comine Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (,6665 2009 30. Name and a r ss of person who completed cause of death (item 23a) (Type, Print) Basil Ct - Largo MD 20174 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH 8888 2/20/09 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Yea **Physician** 9:40 PM Inelma House February 16 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE ST. Asires Hospital 5. Social Security Number 218-18-9227 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Gear) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 85 MI Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 XYes 2 □ No MD Director 10e. Street and Number 10g. Citizen of What Country ō 21229 23a by Funeral filed within 72 hours after death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Blac 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done of the DO NOT use retired during most of working and Mental Hygiene. Elementary Secondary (0-12) College (1-4or 5+) eeping 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental ၉ Brown OHNSON iam 19a, Informant's Name/Relationship (Type i Route Number, City or Town, State, Zip Code) f. 306, Balto, MD 21207 permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trat once. Sister Hanes 20a. Method of Disposition

1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition Baltimore, mi 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Yau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia days /Medical Due to (or as a consequence of) Examiner Sepsis iday Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed burial-transi acidenus day and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 ☐ Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) P.0. 9 I Inknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð CND STAGE RENAC DISEASE cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate cerebral vascular 2 X No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2⊠No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Pangg February 162009 Sodelto Meori 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 BALTIMORE 900 Caton 01029 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FER O A 2000

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20:53 M 2 Date of Death Day **Physician** Leo Aloysius Hughes, Jr. FEBRUARY 16,2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner SALTIMOR **Baltimore City** GNES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M M 2□ F Months Days Hours Min. 72 Director 216-34-2763 MD Apr 6, 1936 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a medial Eventhan must be notified at Catonsville 1 ☐ Yes 2 No Director MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Patleigh Road 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∀es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Aloysius Hughes Jr. Mary Edna O'Ryan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Geraldine Hughes Spouse 309 Patleigh Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ' Department of Important: If its any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 20, 2009 4 Donation 5 Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mull 23a, Part 1. Futer the disce Approximate Interval Between Onset and Death or complications that soused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final Physician Myocurdia intarctio disease or condition resulting in death) hour /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner nding physician and use as the burial-transi Due to (or as a consequence of) certificate be Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea: cate has been signed by the atter page 2 should be detached for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 ☑No 2 13No 1 ☐ Yes 1 □ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 17 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Phy. hours after death. ineral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760, Hospital

> State Registrar

Medical

1014, a Do 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Baltimore, Maryland 2,229 32. Registrar's Signature

900 Caton Avenue

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D47353

29d. Date signed (Month, Day, Year)

February 16, 2009

			1 - State Registrar	of Marylan	•	rtment of F tificate of I		Mental Hygi Red	ene g. No 2009	05195
	-· · ·		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Mary Jane Harr	is				February	7 175 2009	10:00A M
,	Examin	er	4a. Facility Name (If not institution, give street and r Heartfields	number)			Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
	Director		213-28-4146 ^{1□ M 2} ▼F	81	Yrs.	Months Days	Hours Min.	Feb. 17,	1927 Pe	ennsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryli -f sho	ţo	Maryland Frederick			Woodsk	oro			1 XYes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a c	ral	102 Woodsboro Rd.				798		U.S	·
	er de litems	Funeral	Armed Armed	cedent Ever in U Forces? 5 212 No	.S. 13.\	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
036	urs aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, (3 ☒ Widowed 4 ☐ Divorced Year or	Bive		I∐Yes 2⊠No	Specify:		Specify: W	nite
5-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed	4)	i (Give	lent's Usual Occup	during most of worl		6b. Kind of Business	s/Industry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ant, the Madical Evandrier mast be mailthed at	Completed		(1-4or 5+)	life. L	payroll c) -		Federal c	rovornmont
d 2	filed v Hygie other	Be Co	17. Father's Name (First, Middle, Last)		<u> </u>	payrorr		ne (First, Middle, Ma		Overnmenc
<u>la</u>	Mental Mental rked tic ev	To B	Elmer A. Highhouse				Mary K.	VanScoyk		
Maryland	2 short and 1 is mare reuma	ľ	19a. Informant's Name/Relationship (Type. Print)		1			•	City or Town, State,	, ,
e, Z	1 and Health em 27 ther to		Mary A. Cullen/ daughte 20a. Method of Disposition			Woodsbord			o, MD 2179 0c. Location - City o	
mor	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State		sition (Name of natory or other place et Cemete:		9/2009	Frederic	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the "sacted Eventing must be recilled at once.		21. Signature of Funeral Service Ligensee	utler		Name end Addre			neral Homo	
			23a. Part . Enter the disease, or complications tha shock, or heart failure. List only one cause or	t caused the deat	th. Do not ent	er the mode of dyir	g, such as cardiac		•	Approximate Interval Between
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1	/Medical Examiner		resulting in death) Due t	o (or as a consec		EANT	DISEP			
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90,	icate be executed physician and the burial-transit	EX EX	resulting in death) Lest Due t	o (or as e consec	(uence of):					l
38760,		dical	d							
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P.O. Box	at the deat by the att tached for	Physician/M		egnant at time of		Other (specify)	,		Month	Day Year
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rds	v requires been sig should be							1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
Division of Vital Records,	hysicien: The law re his certificete has be I director, page 2 sho	Completed						24a. Was an autopsy perform	ed? prior to	
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uc	ding Phy h. After thi funeral o	ion:	1 Natural 5 ☐ Pending (Me	te of Injury onth, Day, Year)	28b. Time of Injury	Worl	yat ⟨? Yes 2 □No	28d. Describe how	v injury occurred	
isi	or Attendatter deatt Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury . At h	ome, farm, str		ies E 🗆 ito	28f. Location (Stre	eet and Number or F	Rural Route Number,
ă	s after	Certification: To	4 ☐ Homicide determined bui	lding, etc. (Speci	rty)			City or Town,	State)	
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the and me	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	n occurred at the til vestigation, in my o	me, date and place pinion, death occu	e, and due to the ca irred at the time, da	use(s) and manner at te and place, and du	as stated. e to the cause(s)
	To the within To the comple	ğ	29b. Signature and title of certifier			29c. Licens	e number +7951		d. Date signed (Mor	
			I WIL		- 00c \ /T		7 1-15 1		2-17- 7	2007
	6 1		30 Name and address of person who completed ca NBTE A. KAZMI, ND	use of death (Iter	Toll	toust A	UE. FR	EDERICK	MD 2	1701
1	Sta Registi		31. Date filed (Month, Day, Year) 32. FEB 2 0 2009	Registrar's Signa	ature	a. V. I				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** \mathbb{A}^{M} 2009 3:25 February Rebecca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 59 Director 232-78-3194 08/01/1949 MD Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Tollhouse Ave 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Yes. Give þ 3 Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Curtis Hartman Elyard Viola Virginia Likins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once. Jennifer Rico/Daughter 3404 Andover Drive Fairfax, VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Feb 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOILY Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical 38 attending IF FEMALE use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 □ Yes 2 ☑ No ę Month Day Ye ar 5 Other (specify) P.O. ed by the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has The certificate 1 □ Yes 2 No 2 No **Division of Vital** 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REDGRICK MD2170 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar

09-00867 Fred Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 05197 1. For State Certificate of Death Registrar 3. Time of Death 2 Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Fred Douglas Hill 1415 hrs Medical Examiner January 29, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 7851 Crilley Road, Apartment 512 Glen Burnie 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Moriths oreign Country) N.C. Davs Hours 01/27/1953 Director 220 58 1661 1 X M 2 56 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Maryland Anne Arundel Glen Burnie Yes 2 X No 28a-f shov notified at once, the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 512 Crilley Road Apt. 512 21060 U.S.A. or items 23a with 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in:U.S. 11. Marital Status Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 X Never Married 2 X No Yes White f Yes Give Year Yes 2 X No specify: Specify: within 72 hours after Widowed Divorced permit: Pages 1 at 3 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "uatural", injury or other trannatic event, the Medical Examiner. ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed). Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Isaac Hill Lilly McKinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5203 - 6th Street Lee Hill / Brother Baltimore, Maryland 21225 Baltimore, In permit: Pages I at d 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Removal from State X Burial 2 Cremation 3 02/09/2009 Glen Burnie, Maryland Glen Haven Mem. Park Donation 5 Other Specify: 22, Name and Address of Facility Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Hypertensive cardiovascular disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, permE, g888 2/25/09 TT tending physician a X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Chronic alcohol abuse Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene innatient 2 this ٩ 1 ✓ Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 30, 2009 O.C.M.E and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

Registrar

31. Date filed (Morth) Day Year

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT LEE HAYES, FEBRUARY 11 2009 1910 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 4647 BROMLEY AVENUE SUITLAND Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** 1 X M 2 □ F Months Days Hours Director 63 226-60-5111 DEC. 9. 1945 VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 20746 4647 BROMLEY AVENUE USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🗓 No þ If Yes Give Specify Specify. 3 Widowed 4 Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) \$1 and 2 should be filed within the Health and Mental Hygiene.
Item 27 is marked other than SECURITIES PROCESSOR 12TH BUREAU OF ENGRAVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT LEE HAYES, SR. MABLE BROOKS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE C. HAYES / WIFE 4647 BROMLEY AVENUE SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Resurrection Cemetery 02-17-2009 CLINTON, MD 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee 14 DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1 Inter the disease, or comilifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 YEARS LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No o σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð LARYNGEAL CANCER 1 ☐ Yes 2 ☐ No 3 【 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has e 2 s autopsy page perform certificate 2 X No 1 □Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. ours after death. leral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33224 FEBRUARY 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 FOREST GLEN RD STE 435 RAM TREHAN SILVER SPRING, MD 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day February 15, 2009 **Physician** 3:47 Regina Mary Herbert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 220-32-5963 70 June 4, 1938 Director Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Prince Georges Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20707 USA 7548 S. Arbory Way Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Alford Weishaupt Margaret E. Lavender ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10041 Hwy 212, Joliet, Montana 59041 Donald J. Blyton, Jr. - son - in - law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/2009 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Funeral Service Licensee M01234 7601 Sandy Spring Rd, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RIGHT Immediate Cause (Final Physician VENTRIWLAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HOUTE MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CORONARY HRTERY Due to (or as a consequence of) Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by OBESITY 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown ABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy YPERTENSION 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af
I in by the fur 1 □Yes 2 □No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral L 29a. Certifier TGCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR H-401 CHEVERLY STEINBERG 3001 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** ALIVIN /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHOCK TRAUMA CENTER

16. Sex 7. Age (In vrs. last birtha ocurity Number 8. Date of Birth (Month Day Birthplace (State or Foreign Country) **Funeral** 1**∀**M 2□ F 60 Months Days Hours Min 218-46-788 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Eva: there ust be notified **Funeral Director** evern 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene. lomlinson IJS FI 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed th and Mentat Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) inginee 17. Father's Name (First, Middle, Last) Be James tto wa မ lamie Health a 8210 MD 21144 Department of Health Important; If item 27 any Injury or other trople. lom linson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 2.21.09 of Funeral Service Licen 21. Sign sur facility Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PERIFHERAL disease or condition resulting in death) VASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Di ABETES

Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2 Mo 1 ☐ Yes 2 🛣 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Certification: To 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

BOLTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 931 M WALLACE KIRTZ FEBENARY 200 16 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE JOHNS HORKING BAYVIEW MEDICAL CENTER N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1⊠M 2□ F Yrs 219-10-3540 82 June 10,1926 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Dunda1k Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1903 Wills Court United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Oil Company Maintenanceman 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Schultz Stewart Kirtz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

100 Woodland Ave.

Sacred Ht. of Jesus Cem. 2/20/2009

20b. Place of Disposition (Name of cemetery, crematory or other place)

Physician /Medical Examiner

e attending physician and I for use as the burial-transit

signed by the a d be detached for

should has been

this certificate has all director, page 2:

after death.

Director: After this certific

J in by the funeral director,

within 24 hours aff

To the Funeral Di

completely filled in

Completed by

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Page Department o Important: If a

Physician

/Medical

Examiner

Funeral

Director

show

Directo

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Medical Examinating the modified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Physician/Medical

IF FEMALE:

resulting in death)

Immediate Cause (Final

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prostate 32 months Metastatic cancer Due to (or as a consequence of): rostate cancer years, Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery

23b. Was decedent pregnant in the past 12 months?

☐Yes 2 ☐ No 9 ☐ Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1. Natural

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 Thomicide

1 Live birth 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Dundalk, Maryland

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

20c. Location - City or Town, State

Dundalk, MD

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

disease

Malignat

5 ☐ Pending investigation

6 ☐ Could not be

determined

Jennifer Morris (Granddaughter)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

246

Failure - to - thrive

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

autopsy performed? 1 ☐ Yes 2 💆 No

24a. Was an

26. Place of Death (Check only one)

28a. Date of Injury (Month, Day, Year) 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Browner -MO 29c. License number D-0058873 29d. Date signed (Month, Day, Year) 2009 February

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Browner

Johns Hopkins 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Baynew Medical

State Registrar

amend #12 Per FH G889 3/12/09 JH State of Maryland / Department of Health and Mental Hygiene 199 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Zoo 10.051 M W1/1 am hruay /Medical 4a. Facility Name (If not institution, give street and number) 4 County of Death 4b. City, Town, or Location of Death **Examiner** Ellicott City Health & Rehab Center **Ellicott City** Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 217.07.7009 8. Date of Birth (Month, Day, Year Jul 6, 1918 Birthplace (State or Foreign Country) 6. Sex 10 M 2 ☐ F **Funeral** Days 90 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at MD Howard **Ellicott City** 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive 21042 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 2 4 194 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1343 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "nt any injury or other traumatic event, the Macal ODG. Elementary/Secondary (0-12) College (1-4or 5+) photographer newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Klender Irene Seicke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Heist 4990 Threshfield Court Ellicott City, MD 21043 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Atlantic Crematory, LLC Feb 19, 2009 Glen Burnie, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Pote the dispase, or complications that shock, or heart failute. List only one cause of Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Candara aular PIseno Immediate Cause (Final disease or condition Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No 2 1 🗀 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Director: After Injury Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Medicai and manner stated. 29c. License number D 3 0 6 4 / 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 9 Back RIVEN Neck Read Baltin Ramesh Sabapathy 201-109 Back RIVEN Neck Read Baltin Maylad 2122 31. Date filed (Month, Day, Year)-32. A gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Apply Name (if not institution, pine street and number) Apply Name (if not institution) Apply Name (if n				Please	Type or Prin						•		-		
Physician As Early Name (if not institution, gave sirred and number) Early Name (if n			State Registrar			ai yiai u	-				ivientai n		2000	05	204
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10s. State 10c. Colly. Town or Location 10s. Colly. Town	Funera	1	5. Social Security N 220-52	Jumper 6. :	SP, VAL	e (In yrs. la:		12c	r 1 Year	JMON If Under 24 Hrs	8. Date of B	irth Day, Year)	Bali 9. Bii	timore Cit	
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e of the total state of the tota	be executed ician and burial-transit	=	that illitiated events	5	c	•									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	t the death certificate by the attending phys ached for use as the	hysician/Medic	23b. Was deceden in the past 12 1 ☐ Yes 2 [months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	death 3 □			,		2			Ye ar
24a. Was an 24b. Were autopsy findings avai	quires tha an signed uld be det	2	Part II. Other sign!	ficant conditions	contributing to death be	ut not resulti	ing in the ur	derlying o	cause give	en in Part I.				/	death? / Unknown
26. Place of Death (Check only one) Swas case referred to medical examiner? 1 Yes Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	aw as t										auto per	opsy formed?	death?		available cause of
27. Manner of Death Natural 28a. Date of Injury 28b. Time of	ysiciai is certi directo	0	examiner?		Hospital:	ent 2 🗆 El	R/Outpatien	t 3 🗆 D	OA Othe				□Other (Spe	acifu)	
The property of the property o	ending Ph eath. or: After th	ation: T	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	on		28b. Time of	- 1	28c. Injury Work	at ?				Jony	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ital or Att urs after de ral Directe		4 Homicide	determined	building, etc						City or To	own, State)			nber,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	e Hosp 24 hou e Fune letely fi	dical	(Check only	1 Certifying P 2 Medical Exa	miner: On the basis of	f examination	ledge, death on and/or inv	occurred estigation	at the tin	ne, date and plac pinion, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(5)
	To the vithin To the comp	Me	29b. Signature and	title of certifier											
150236 Februray 14,20			M	7500	m	_			15	01-3 e	5	Feb	/U/AI	7/4,	2009
30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) TUINT BONACIMMO 30) 5 TPAUL PLACE BALTIMONE MO State 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	5 V		30. Name/and addr	. //		eath (Item 2	23a) (Type, I	Tint) P	AUI	- PC	uce 1	Bar	TTMI	MEM	Ω
State State 31. Date filed (Month, Day, Year) Registrar 32. Registrar's Signature 32. Registrar's Signature				th Day Year)	32 Benistra	ar's Signatu	re	m. cl.	9			774	121110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2/20

Amend Item State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death Reg. No. 05205 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2112 PM Gorman R. King February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 t. Annes 5. Social Security Number altimore 8. Date of Birth (Month, Day, Year) Dec 2, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min 79 Dec Missouri Director 219-32-6239 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d, Inside City Limits 28a-f show ¬ is marked other than "natural", or items 23a or 28a-f show
traumatic event, the Medical Evantimer and the notified at
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→ The Medical Evantimer and the medical Evantimer and Evantimer and Evantimer and Evantimer and Evantimer and Evantim Director 1 ☐ Yes 21 No MD Howard **Elkridge** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21075 5815 Harman Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 4 es 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No white 48-52 Specify: þ 3 Widowed 4 Divorced Completed unk unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mentat Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Halena Miller Richard Wesley King ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau St. Agnes Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signatur Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street lirector Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Unknewn 5/9/1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine neral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran 16 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 ANo death? 1 □ Yes 2 □ No 1 □ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D cal 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116000 31. Date filed (Month, Day, Year) Registrar's Signature State arks Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PM FIERUARY M 9000 RSIOPL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WORE 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, **Funeral** Min. Days Hours 1 □ M 2 1 F Months 0 1390 Director 220 12 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ! 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "Modeal Exercity", and be notified at 1 ☐ Yes 2 No Director BALLIMORZ JARY LAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any linjury or other traumatic event, the Midtel Eventual once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**%** No Specify þ 3X Widowed 4 ☐ Divorced 1116 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🛮 🗟 🔾 🔾 👢 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State FEB. 3 ™ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 000 21. Signature of Funeral Service Licensee だいほうはい IS JAHIJ. HON CHONTAN CORRES Not 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHF Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Dm tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Acrhi Stemusi 3 Probably 4 Unknown 1 □ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 29a. Certifier 🏂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ma 70) 21206 K-10252 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

		For State Registrar	State o	f Marylan		artment of F rtificate of I			giene 20	09 05207
Physicia /Medica	al .		RENZ				(2)	2. Date of Dea Month	2 17 2	3. Time of Death
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	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Dec	2 ⊋No ve	'	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	212 Iispanic Origin? (San, Mexican, Puerl	pecify Yes or No-		States American Indian, White, etc. White
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To the Hos within 24 h To the Fun completely	Medical	(Check only 2 ☐ Medical sone) 29b. Signature and title of certifier	=xaminer : On the l	pasis of examina	ation and/or in	29c. Licens	opinion, death occ	urred at the time, o	date and place, and	d due to the cause(s)
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5			Registrar 1. Decedent's Name (First, Middle, Las	t)		ertificate of	Death	2. Date of Dea	.eg. 1107	
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			Oak Crest			Parkv			Balt	imore
	Funeral Director		5. Social Security Number 6. Security Number 219-34-6679 Usual Residence of Decedent	7. Age (In yrs. 94	. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept	Year)	Birthplace (State or Foreign Country) Maryland
	yland now at		10a. State 10b. County		ty, Town or L	ocation				10d. Inside City Limits
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980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	1 □ Never Mamied 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	.3.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Pican, etc.)	14. Hace - Ai Black, W Specify:	merican Indian, hite, etc. White
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Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumatic	•	19a. Informant's Name/Relationship (7) Edward R. Limmer	rpe. Print) – Son	19b. Mail 5175	ng Address (Street a	and Number or Rura	l Route Number,	City or Town, State	. Zin Code)
ore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	ate	20c. Location - City	or Town, State				
tim	t. Pag tment tant: ijury o		4 ☐ Donation 5 ☐ Other (Specify)	DI	watory or other place Valley	Feb.	14.2009	<u>Timoniu</u>	ım MD	
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or Vital	certif	∞	25. Was case referred to medical examiner?	ospital:			26. Place of Death			
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4	within To the compli	2	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
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	り	3	60. Name and address of person who con	11.00			1 0 /			
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DHMH 17 Rev 1/2001

Limme, Dorothy alujos 43Am

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State of Maryland / Department of Health and Mental Hygiene

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	Physic	ап	Decedent's Name (First, M				_			2. Date of D Month	eath	ay	Year	3. Time of Death
C_{ij}	/Medi Examir		MARY 4a. Facility Name (If not instit		THOMASINE ve street and number)	LEOPOI	TD T	4b. City, Town,	or Location of Dea	<u> Febru</u>	$\overline{}$	11, 2	2009 of Death	12:45 A
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	Funeral Director		5. Social Security Number 220–28–7969	6. 9		e (In yrs. last bir	thday) _ Yrs.	If Under 1 Year Months Days			irth Day, Yea 5 , 1		9. Birthp	lace (State or Foreign try) Land
	and		Usual Residence of Decedent 10a, State 10b, Cou			10c. City, Towr	n or Loc	ation					11	Od. Inside City Limits
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21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show na Prodicut Exsmirer must be notified at	þ	1 Never Married 2 1 3 Widowed 4 Divor		Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Yes, specify Cub	Hispanic Origin? (i pan, Mexican, Puel Specify:	rto Rican, etc.)	10-	Black	k, White, e	etc.
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Baltimore, Maryland	000		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati 4 ☒ Donation 5 ☐ Othe	(Speci	fy)	cemeter	f Dispos ry, crem	ition (Name of atory or other pla	ce)	Date	20c.	Location -	City or To	wn, State
Balt	permit. Pag Department Important: I any injury o		21. Signatul Cuneral Sen	1/	1/1/1/1	1	Ba.	ltimore.	ess of Facility Omy Boar MD 212	01		1timo	re S	treet
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			30. Name and address of pers	0		. , ,		^{rint)} morial H	Ospital					1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01412 State of Maryland / Department of Health and Mental Hygiene 05210 2009 Alison A. Lindley Certificate of Death Reg. No 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day February 17, 2009 1738 hrs Physician/ Alison A. Lindley Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Bel Air 1113 Jade Drive 9. Birthplace (State or 8: Date of Birth(MM/DD/YYYY If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours CountryCanada Months 10/2/1955 53 229-88-8953 Director M 2XF 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Bel Air Harford MD s 23a or 28a-f show e notified at once. 10g. Citizen of What Country? death with the Maryland Director Of, Zip Code 10e. Street and Number U.S.A. 21014 1113 Jade Dr 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. 1 Never Married 2 Married White Yes Specify: Yes 2 X No specify: 0 If Yes. Give Yea Divorced Widowed 16b. Kind of Business/Industry hours after 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) .Ã "natural" 15. Decedent's Education (Specify only highest grade completed) Completed altimore, MD 21215-0036
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partient of Health and Mental Hygiene,
portant: If item 27 is marked other than "nat
ury or other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christabel Hewetson Robert Norman Lindlev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2706 Raynham Ct Baldwin, MD 21013 John Lindley/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 2/19/2009 Beltsville, MD Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Towson, MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Physician failure. List only one cause on each line. Medical Seizure disorder Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Records, P.O. Box 68760, The law requires that the death certificate be executed 23a,27,perME, g889 3/31/09 TT Physician/Medical AMENDED tending physician a X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown ģ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy death? performed? has 1 🗸 Yes ✓ Yes 2 No certificate h 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Other₄ Residence 6 🗸 Other: Scene Division of Vital Be Nursing Home 5 DOA Hospital: ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28c, Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 18, 2009 O.C.M.E.

Or pero

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

CED 9 0 2000

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 8:172 AM. 2 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** saffinere Rehabilitation Extended care NI selfinose 5. Social Security Number 7. Age (In yrs. last birthday) 91 Yrs. Year If Under 24 Hrs. . Sex 1 M 2 □ F Date of Birth (Month, Day, Year) 12/12/1917 9. Birthplace (State or Foreign Days Maryland 215 01 6871 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director**

Glen Burnie

10f. Zip Code

21061

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Anne Arundel

12. Was Decedent Ever in U.S. Armed Forces?

108 Cromwell Avenue

05211

1 ☐ Yes 2 K No

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian,

Black, White, etc.

Funeral Director

> Maryland 10e. Street and Number

11. Marital Status

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician 🦸 /Medicat Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit

Division of Vital Records, P.O. Box 68760,

QX

State Registrar DHMH 17 Rev 1/2001

Ę	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No If Yes, Give τπι ττ	4.50	2 K No	Specify:	,,	Diack, V	vriite, etc.		
d b	3 🖾 Widowed 4 □ Divorced		Specify: White							
lete	15. Decedent's Edu (Specify only highest grad	lcation de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry			
Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NO Optici		d)		Eye Glass Company			
ပ္	17. Father's Name (First, Middle, Last)	den Surname)								
ě P) Lepson Bertha				(not available)				
	19a. Informant's Name/Relationship (7) Mildred Miller	/pe. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Eugenia Avenue Glen Burnie, Maryland 21061							
	20a. Method of Disposition	lace of Disposition (Name of ace of Disposition (Name of ace of Disposition of the place) Date 20c. Location - City or Town, State								
	1 A Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	n Haven Mem. Park 02/18/2009 Glen Burnie, Mary								
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225									
	23a. Part 1. Enter the disease, per plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. Let all yone cause on each line. Immediate Cause (Final disease or condition)							Approximate Interval Between Onset and Death		
	resulting in death)	Due to (or as a conseque	ence of):				-			
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
dical Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac							co use contribute to the cause of death?		
g p	Coronary artery Disease							2 No 3 Probably 4 Unknown		
omplete	24a. Was an autopsy performer 1 □Yes 2 ☑							24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No		
e C	25. Was case referred to medical	1140	res 2 🗆 140							
0 E	25. Was case reterred to medical examiner? 1 Yes 2 No									
ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	28b. Time of Injury M	28c. Inju Wo 1 [ry at 2	8d. Describe how injury occurred				
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fac	factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
edical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exam	(Check only 2 Medical Examiner: On the basis of examination end/or investigation in my oninion death occurred at the time date and place and due to the cause(s)								
Ž	29b. Signature and title of certifier	Colom	0	29c. Licens	se number		Date signed (M	lonth, Day, Year)		

ORIGINAL

Bodsvard, Beltimine, Margael

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

och Kaven

32. Registrar's Signature

3900

11.2

31. Date filed (Month, Day,

			For State Registrar	State of Marylan		artment of F			ene . No. 2009	05212	
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
Mag	/Medic	al	4a. Facility Name (If not institution, give st		iller	4b. City. Town, or	Location of Death	February	18 2009 4c. County of Death	12:55 AM	
	Examin	er	Sînai Hospita	l of Ballir	note	Rall	more		40. County of Dean	,	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)	
	D		Usual Residence of Decedent 10a. State 10b. County					Dec. 28,	120 111	aryland	
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the "Modeal Even the "outle be rediffied at	tor			, Town or Lo	esville				10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	or 28a	Funeral Director	10e. Street and Number		. 110	10f. Zip Code		10g	. Citizen of What Cou	untry?	
	eath w	eral	4535 Mary K	no I Road . Was Decedent Ever in U.S	3 13 1	Mas Decedent of H	58 ienanic Origin? (Spe	city Voe or No	14. Race - Amer		
9	after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give		f Yes, specity Cuba	ispanic Origin? (Spe an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White	, etc.	
21215-0036	hours tural",	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:		dent's Usual Occupa		16	b. Kind of Business/li	rite	
215	thin 72 ie. an "na Mudic		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of workin ()	g I	b. Airig of Dasiliess/ii	laustry	
d 21	illed wi Hygien ther th	Con	17. Father's Name (First, Middle, Last)		Gene	rai Lab	18. Mother's Name			Baltimore	
Maryland	should and Mer is marke aumatic	To Be		riller			Mart		Curne	les	
Jar			19a. Informant's Name/Relationship (Type				and Number or Rural		ity or Town, State, Z		
	f Health fem 27 other tr		Calvin P Miller 20a. Method of Disposition	- brother 20b. PI	720 E ace_of Dispo	sition (Name of natory or other place		Rd W	occibine, no. Location - City or T	no 21797 own, State	
Baltimore,	Pages ment of I ant; If Ite ury or o		1 Mx Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	Ilovariioni State		Faith Cem	1 111	010 -	osedale, n		
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee			Name and Address	ss of Facility	\$ Crema	ution Service	es- Parkville	
			23a. Part 1. Enter the disease, or complica	tions that caused the death			ford Rd. g, such as cardiac or	respiratory arrest	e marylano	Approximate	
4	Physician	ł h	shock, or heart failure. List only one Immediate Cause (Final disease or condition	^	n Pr	emen	۵.			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	10011 1014				11 days	
	D #	ner	Sequentially list conditions, if any adding to immediate cause. Enter I inderlying	Due to for as a consequ	eng. of					10 days	
	xecuter and I-transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	In Ya Pare Due to (or as a consequence)	nchyr	nal bl	leeding			4 days	
8760,	cate be executed physician and the burial-transit	dical E	d.	Dao to (of do d corrisequ	cride oi).		O			,,,	
ပ	ertifica ling phy e as th	Medi	IF FEMALE:				-				
Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as t	Physician/Me	in the past 12 months?	 If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deli- Month	very Day Year	
P. O.	w requires that the d been signed by the should be detached	hysi	1 □ Yes 2 🔼 No 9 □ Unknown	9 🗀 Unknown							
	ires tha signed	5	Part II. Other significant conditions contr	buting to death but not resu	lting in the ur	nderlying cause give	en in Part I.		co use contribute to 2 X No 3 ☐ Pro	the cause of death?	
COL	s been should	Be Completed						24a. Was an		opsy findings available	
- B								autopsy performed 1 □ Yes 2 X	prior to co	ompletion of cause of	
Vita	ician certifi ector		25. Was case referred to medical examiner?	spital: 🖦		Othe	26. Place of Death	(Check only one)			
ס ר	ding Phy h. After this funeral di	n: To	27. Manner of Death	1 A Inpatient 2 L	ER/Outpatien 28b. Time of Injury	t 3 DOA 28c. Injury Work	4 Li Nursing Hom	e 5 Residenc 3d. Describe how i	e 6 Other (Specinjury occurred	ify)	
Division of Vital Records,		catio	1 🔀 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			_ M 1□\	Yes 2□No				
DIX		Certification: To	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
			loneck only 2 Wedical Examine	ian: To the best of my know	vledge, death	occurred at the time	ne, date and place, a	nd due to the caus	se(s) and manner as	stated.	
	To the I within 2 To the I complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License			Date signed (Month,		
	- > - 0		K. Kusma	MD							
Ý			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I	Print)		a Al-	ebruary,	10/2009	
100	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati	2 j Maj	MOJPI)	ray of	Baltim	026		
	Registra	ar	FEB 2 0 2009	A December 1	do	Kel					

DHMH 17 Rev 1/2001

Patient Known of Miller, Sharon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05213 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6.05 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Richey Hospice Baltimor If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sey 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days 52-0370 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f show Examiner must be notified at Kar 1 ☐ Yes 2 ☑ No Funeral Director Manyland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: Back Completed by 3 Widowed 4 Divorced item 27 is marked other than "nature other traumatic event, it is invalidation. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Contracto. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomasina Howard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Screathia DISMe -daughter 1700 North 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Dispositio 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee or roximate or rval Between nset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No Vital the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Yes 2 | 1 No Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To ð After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred **Division** 5 ☐ Pending investigation 1 TYes 2 No after death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide e Funeral I Medical 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 400 10426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINJ-32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			. For	State of Maryland	I / Depai	tment of F	lealth and l	Mental Hy	giene		
	1 - State Registrar				Certificate of Death				Reg. No. 2.0.00 05211		
	Physici		1. Decedent's Name (First, Middle, Last)	centelli				2. Date of Dea Month Februa	- 1/	3.1 ine of Death	
No. of	/Medi Examir		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Dear		
· de			Genesis Nursing H	Home Perring P	kwy.		Parkvill	e	Bal:	to.	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th 9. Bir	thplace (State or Foreign ountry)	
и	Director		212-07-9421	IM 2XC) F 92	Yrs.	Jay C		Rebruary	28,1916 P	ennsylvania	
	pu: w		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loca	ation				10d. Inside City Limits	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	5	Toa. State	Toc. Oity,	TOWIT OF LOCK	111011				1 ☐ Yes 2 ☐ No	
		ect	Md. Balto			Nottingh	am		40 - Citi et 18/h et Ce	Λ	
		늅	10e. Street and Number			10f. Zip Code	006		10g. Citizen of What Co	·	
		Funeral Director	4033 Jacinth Way	7 12. Was Decedent Ever in U.S	10 W		236	posify Voc or No		USA	
	item item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo	. 13. vv	Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black, White		
36	rs aft	by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	⊒Yes 2⊠No	Specify:		Specify:	White	
ŏ	tura sel E	Completed	15. Decedent's Educ		16a. Decede	ent's Usual Occup	pation		16b. Kind of Business	Industry	
715	in 72		(Specify only highest grade Elementary/Secondary (0-12)		(Give ki life. De	ind of work M one of NOT use retired	during most of wor d)	king			
21215-0036	s with	E O	12	College (1-401 5+)	Homem	aker			Home		
	uld be filed Aental Hyg rked othe tic event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	-	
<u>lar</u>		TO E	Frank Macciantell	li			Joseph	ine	Unknown		
Maryland	should I and Men s marke tumatic	П	19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mailing	Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State, a	Zip Code)	
	and 2 allth 27 i		Adelio F. Maccent	elli Son		4033 Jac	inth Way	Nottine	ham. Md. 2	1236	
ore.	of He		20a. Method of Disposition	20b. Pla	ace of Disposi	tion (Name of story or other place		Date	20c. Location - City or		
Ĕ	Pages 'nent of Hant: If Ite	i	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		emetery	· :	-2009	Balto. Md.		
Baltimore,	permit. Pages 1 and: Department of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Funeral Service License	ee	22.	Name and Addre	ss of Facility	Schimune	k Funeral I	Home	
Ω	89 = 29		Bur all	elen	97	05 Relai	r Rd No	ttinoham	. Md. 2123	5	
1	Physician /Medical Examiner	بر	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Betw Onset and D Due to (or as a consequence of): Sequentially list conditions,								
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the lime of de 9 □ Unknown	death 3 🗌	Ectopic pregnand Other (specify) _	у		23d. Date of de Month	livery Day Year	
	that ned b deta		Part II. Other significant conditions cor		ting in the und	lerlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?	
rds	luires n sign lld be	d b	Senile dementia					1 ☐ Yes 2 ☒ No 3 ☐ Proba		robably 4 🗆 Unknown	
of Vital Records,	The law requir cate has been s page 2 should	Completed by						24a. Was autop perfo 1 🗀 Yes	psy prior to rmed? death?	utopsy findings available completion of cause of	
Vit.	iclan: The certificate ector, pag	a	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Dea				
ot	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	P.	Po 1 Tes 2 No Hospital: 1 Inpatient 2 Fe/Outpatient 3 DoA Other: 4X Nursing Home 5 Resi						dence 6 Other (Specify) how injury occurred		
		io	1 Natural 5 ☐ Pending	Injury	Wor	k? Yes 2 ⊡No	200. Describe i	Thow Injury occurred			
Division		Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)						treet and Number or Rural Route Number, n, State)		
		Medical C	29a. Certifier 1 Certifying Physical Certifying Physical Check only one)	cause(s) and manner a date and place, and due	cause(s) and manner as stated. date and place, and due to the cause(s)						
	To th To th comp	Me	29b. Signature and title of certifier	161		29c. Licens	e number		29d. Date signed (Mont	th, Day, Year)	
	, 0		Suma	Khomoy	9	D00	58965	F	ebruary	19th 2009	
-			30. Name and address of person who co			rint) 180	I Wen	twort	ebruary h Road 21234	(II	
			Of Date Glad (Marris Day 16 and	OO Servicture de Circurt		1	C111101C		1		

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb. **Physician** Anna V. McKinney 2009 0944a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ 4 Months Days Hours Min. 220-07-7765 88 Director Aug. 26, 1920 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machinal Evantinar must be notified at Director Baltimore Essex 1 ☐ Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Grove Manor Drive 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates 9 Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental should be MAble Knight Joseph Savlo ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s' ment of Health ar Ronald Toft /son Sugarboot Lane Hanover PA 17331 Baltimore, t; If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages Department o Important; If I any Injury or 1

Burial 2 □ Cremation 3 □ Removal from State OAk Lawn Cemetery 2/20/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Coll Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UROSEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician; The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy ō Month Year Day 5 Other (specify) the 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ISCHEMIC CARDIOMY OF ATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate has funeral director, page 2: autopsy perform ATRIAL FIBRILLATION 2 □ No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \infty Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and title of certifier D64395 30. Name and address of pe pleted cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMONE, MD 21204 DANIEUE DOBERMAN, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Mangaret Mc/ 4a. Facility Name (If bot institution, give street and number) 2 10 09 4b. City, Town, or Location of Death 4c. County of Death Baltimore Charlestown Nursing Home Catonsville Birthplace (State or Foreign Country) PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Hours Months 1 □ M 2 🗓 F 94 Yrs. 07/16/1914 205 03 0887 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 TXNo Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane RGS235 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: <u>م</u> 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ years Elementary/Secondary (0-12) Guidance Counselor Prince Georges Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James McAvoy Margaret Shanley ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann E. Pyles 209 Old English Oak Ct. Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vincent Cemetery 02/20/2009 Plymouth, PA. 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter or userlying Cause (Disease or injury that initiated asserts. Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 2 No 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Meany Injury or other traumatic event.

the Medical Examiner must be notifled at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and attending physician After To the Funeral Director: Aftractors of the Funeral Director: Aftractors of the Funeral Directors of the fur

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be P 27. Manner of Death Certification: 2 Accident 3 ☐ Suicide 4 ☐ Homicide

1 Yes 2 No

5 ☐ Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

I 🚅 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Choice Lane

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

(Check only

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowlin mo

Catonsville

State Registrar

DHMH 17 Rev 1/2001

Medical

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2009

			For State Registrar		Cei	rtificate of I	Death		Reg. N	2009	05217
	Dharisi		1. Decedent's Name (First, Middle, La	ast)				2. Date of De	eath		3. Time of Death
	Physicia /Medic		Bernard	d Joseph Meinsc	chein,	Sr.		Februa	cy 1	ay Year .7, 2009	12:24 P.M
	Examin		4a. Facility Name (If not institution, gi	•			Location of Death		4	c. County of Deat	h
-			Stella Maris			Timoni				Baltimo	ore
	Funeral Director		219-18-7115	Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F	last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, P 1/12/	rth ay, Year 1925	9. Birr Co Balt	thplace (State or Foreign funtry) Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	f show	5	Maryland Baltin		ckeysv						1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number		70110101	10f. Zip Code			10a C	citizen of What Co	untry?
	s 23a or	eral Di	401 Wake Robin			210	030		Urı	ited Sta of ameri	tes ca
.4 р.т. 0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be indiffied at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ⊡Yes 2√2No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or N Rican, etc.)			e, etc. White
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2	ed wi	Co	12	3	Super	visor of	engineer			WBAL-TV	
17, 2009 Maryland	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Las				18. Mother's Name			,	
× 28	ould I M. r narke	ို		nn Meinschein			Mary A				
7, Mai	12 st th and 7 is n traun		19a. Informant's Name/Relationship Mrs. Beverly S. A		19b. Mailir	ng Address (Street	and Number or Rur	al Route Numi	ber, City	or Town, State, 2	Zip Code) 21030
	1 and Heal em 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	in Drive	Cockey		LIC, Mar Location - City or	
JAR	Pages nent of ant: If it		ttata 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Control o	T Bomovol from State	emetery, crer	natory or other place Valley Vial Garde	e) Fahr			•	Maryland
FEBRUARY Baltimore,	per nit. Pages 1 and 2 should be filed within Detertment of Health and Min mal Hygiene. Important: If item 27 is marked other than any Injury or other traumati event, the Meons.		21. Signature of Furleral Service Lice		20	Name and Addre	se of Facility				ion Ctr.,P.A d 21093
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50,	be exectan a		resulting in death) Last	Due to (or as a consequ	uence of):						
N 68760,	cate I ohysi the b	Medical		d							
BERNARD MEINSCHEIN al Records, P.O. Box 6	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Ideath 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у			23d. Date of de Month	ivery Day Year
E.S.	at the ded d by the etached	Phy		contributing to death but not see	ulting in the co		on in Doubl	22a Did	toboses		the cause of death?
Records,	w requires that been signed I should be det	by	Part II. Other significant conditions	contributing to death but not rest	unung in ine u		en in Part I.				robably 4X Unknown
NA	law re as be 2 sho	Completed						24a. Was		24b. Were at	stopsy findings available completion of cause of
33 H	The ate h page	ĕ						auto perf 1 □Yes	ormed? 2 X IN	death?	
BE Vital	siclan: The law s certificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?				26. Place of Deat				
of \	Physic this c al dire	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	,		4 Li Nursing Ho	me 5 🗆 Res	idence	6X Other (Spe	cify) HOSPICE
E C	ding Ph h. After th funeral	io i	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl		28d. Describe	how inj	ury occurred	
Sign	r Attend er death rector; / by the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to				Yes 2□No				
Division	tal or Atten s after deatl al Director; ed in by the	Certification:	4 ☐ Homicide determined		ome, farm, str	eet, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or Ru te)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa one) X Nurse Prac	hysician: To the best of my knouncer: On the basis of examination to the examination to the basis of examination to the basis of examination to the basis of examination to the basis of examination to the examination to the examination to the examination to the examination to the examination to the examination to the examination to the examination to the examination to the examination to the	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place, pinion, death occur	and due to the red at the time	e cause , date a	(s) and manner a nd place, and due	s stated. to the cause(s)
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			> Johnes	enry		R14	9192		21	17/200	9
CIL			30. Name and address of person who		, , , , .	,					
04 1	Sta	te	JACKIE JONES, CRI 31. Date filed (Month, Day, Year)	NP 2300 DULANE 32. pegistrar's Signa		EY RD.	CIMONIUM,	MD 210	93		
V	- Ota		EED O A o	222	8						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Beparament of Health and Mental Hytiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Cherie Rae Mettee 2009 7:23 P. 13. February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. . Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 214-24-8708 1 □ M 2√2 F 81 8/25/1927 Balt., Maryland Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the 'Nedical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10f. Zip Code 10e Street and Number 10g_Citizen of What Country? 221 Divison Avenue 21093 of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo white Specify <u>≨</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate If Item 27 is marked other or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be f Millard Baker Evelyn Ray Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Martin Russell Mettee/spouse 221 Divison Avenue Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air February 20c. Location - City or Town, State 20a. Method of Disposition j Department of Important: If It any Injury or conce. 1 ☐ Burial ② CiCremation 3 ☐ Removal from State 15, 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examinet law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) P.O. has been signed by the e 2 should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy page certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2V No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29b. Signature and title of certifier

State Registrar

Registrar FER 9 (1

WILLOW MD 555

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:44PM Ebruary Nowowie 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner HARBOR Baltimore City HOSP, MAL | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | Apr 19, 1923 | Mary Land Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2 □ F 85 215-12-3018 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linity or other traumatic event, the Medical Evernine. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No Funeral Director Md. Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 1305 Bethlehem Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 27 Married 2 No 1 ☐Yes 2 No Specify ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Machine Operator 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Lipka John Nowowiejski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9724 Silver Farm Court Perry Hall, Md 21128 Joyce R. Baublitz(niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-25-2009|Baltimore,Maryland Holy Rosary Cem. 22. Name and Address of Facilin Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ~ unknown Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) n signed by the a 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Artiny disease Coronary 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Diabetis 1 ☐Yes 2 ☑No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 200 MO 2005

Registrar
DHMH 17 Rev 1/2001

State

HANDOVER STREET

BBITIMORE

MO21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGELIM

31. Date filed (Month, Day, Year)

ESMOILUR 3001 SOUTH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2009 NICKENS CORRINE -eb 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WALKERSVILLE GREENWICK DRIVE FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2ØF Days Hours Min. Months 217-32-6764 MD. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at MO. FREDERICK WALKERSVILLE 1 ØYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 GREENWICK DRIVE USA 21793 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NURSING ItoME alth and Mental Hygiene.
27 is marked other than "In traumatic event, It is Men Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT 12 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item Z7 is marked oth any liviny or other traumatic event one. 18. Mother's Name (First, Middle, Maiden Surname) Be STERLIN G HOLLAND MYRTLE DIGGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/793 19a. Informant's Name/Relationship (Type. Print) (DAU) 126 GREENWICK DR. WALKERSVILLE MO KATHY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-12-09 FREDERICK, MD. FAIRVIEW Com. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. HOME 21. Signature of Funeral Service Licenses FLOOTRICK MO 21701 110 WEST SOUTH ST 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOScherosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Type 2 OM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury-that initiated events Examine burial-transit requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate l 1 □ Yes 2 D No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certification: To 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pleath.
within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

3

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

(uyene 15.

ELLCENE B. CASHWEYA

(asu41

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

State Registrar

29c. License number

1)40307

MD 1584 CAROSSORIANTAIN PIKE PERSONUR MD 24703

29d. Date signed, (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** DELURES 200 g OWENS 17:32 M PEB 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARY LAND MEDICAL BALTIMORE 737 HE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month_Day, 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at MD 1 Yes 2 No Director altimole 10e. Street and Number Citizen of What Country? 23a or Pages 1 and 2 should be filed within 72 hours after death with 10 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ⊟Yes 2 ₩ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 P. 1 ☐ Yes 2 ☑ No þ Specify. 3 ₩idowed 4 Divorced "natural", Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier

27 Is marked other the traumatic event, Inc. . Father's Name (First, Middle, Last) Be Burnett မ anicl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) Daughter Health a 4005 C 'kanston item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If iter any injury or ott once. 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation ✓ □ Other (Specify) 22. Name and Address of Facility 21. Signatu Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** PAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CELLULITIS DAMS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed NON SMALL CELL LUNG CANCER 4 MONTHS attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by s peen s 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 sl 24a. Was an autopsy performed? Yes 2. No After this certificate 1 □Yes 2 □ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

10

State

Registrar
DHMH 17 Rev 1/2001

22 S. GREENE ST.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE C. KOCHMAN III

31. Date filed (Month, Day, Year)

1255590147

BALTIMORE, MARYLAND

FEB

16 2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05222 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 18, 2009 **Physician** 12:41 P M James Kenneth Powell, Sr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 13663 Bottom Road Hydes | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (Secondity) | March | 11, 1937 | Georgia 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F 218-32-6465 71 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be reutified at once. 1 ☐ Yes 2 No Funeral Director Baltimore Hydes Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21082 13663 Bottom Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No 1955 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TV Technician Electronic Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Powell Frances Jones ပ 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 13663 Bottom Road, Hydes, Maryland 21082 Betty Jean Vercher Powell 20b. Place of Disposition (Name of Eval's Fureral Captel & Cremation Svcs. Bel Air 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 2/20/2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Evans Funeral Chapel & Cremation Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, enheart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death **Physician** artery pages disease or condition resulting in deeth) ormary /Medical Examiner orges tire Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. , Dertensiu 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No neral Director: A investigation death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number M2 30. Name ≰nd address of person who completed cause of death (Item 23a) (Type, Print) Green St. Battimore, MD Frederick 13. Kotler, M.D. N. 31. Date filed (Month, Day, Year) ----32. Segistrar's Signature

Registrar

State

			1 - For State Registrar	State of Ma		ertificate of L		ental Hyوب ۶	giene Reg. No. 2009	05223		
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month		3. Time of Death		
	Physici /Medio		Garry Dean P	ence				2	17 2009	1035 AM		
	Examir	er	4a. Facility Name (If not institution, g	·			Location of Death		4c. County of Death			
10			FRANKLIN Sauce 5. Social Security Number 6.	re HOSPITO	(In yrs. last birthday	Rose	If Under 24 Hrs.	9 Data of Birth	Baltim	place (State or Foreign		
^	Funeral Director		217-56-8330 Usual Residence of Decedent	1 1 M 2 D E	7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Decembe	r 18,1951 W	ntry) est Virginia		
	ryland show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
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	vith th		10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Cou	ntry?		
	sath v	erai	508 Scholar Co	T		Mrs Dandant Mil	21040		SA			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the Inciting at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	verin o.s.	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🎇 No		Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
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an	ld be lental ked c	To Be	Preston H. Pence	,			Leona R.		,			
ary	shou and N s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street a	and Number or Rui	ral Route Numbe	r, City or Town, State, Zip	o Code)		
Z,	and 2 ealth a n 27 is		Carol Pence	Spouse	508	Scholar Co	ourt Edg	gewood, l	Md. 21040			
ore	jes 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	e)	Date	20c. Location - City or To	own, State		
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Ba	permi Depar Impor any ir once		21. Signature of Funeral Service Lice	nsee	·	22. Name and Addres 9705 Bela:	ir Rd. Sch	imunek Etingha	Funeral Home	5		
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/ita	cian; ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)			
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18	Attender death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to		v - At home, farm, st		′es 2□No	28f Location (St	treet and Number or Rura	I Route Number		
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	e Hospita 124 hours 1e Funera sletely fille	Medical C	29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of approximanner state	examination and/or i	th occurred at the tim nvestigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	cause(s) and manner as s late and place, and due to	stated. the cause(s)		
	To the within comp	Me	29b. Signature and title of certifier	1		29c. License		2	9d. Date signed (Month,	Day, Year)		
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			State Registrar				Ce	rtificate o	f Deat	h			200	9	05224
	Physic	ian	1. Decedent's Nam	ne (First, Middle,	Last)						2. Date of D Month	D	ay Ye	ar	3. Time of Death
	/Medi			EAN PANZ							02		9 200		8:25 AM M
	Exami	ner			give street and num	ŕ		4b. City, Town			_	4	c. County of E		
	Funeral	~	5. Social Security N		e Medica	l Cente 7. Age (In yrs.			ir, Mar If Und	<u>aryla</u> er 24 Hrs.	8. Date of B	irth	Harfor	rd Birthpla	ce (State or Foreign y)
	Funeral Director		218-40-		1 □ M 2 X F	65	Yrs.	Months Day	ys Hours	s Min.	09/22/	ay, Yea	r) M	Countr arv	land
10	P.		Usual Residence of	of Decedent							10277				
82	aryfar show	_	10a. State	10b. County			ty, Town or L							100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
0	he Ma	Director	MD	Balti	liliore	Kı	ngsvi					40- 0	NA:		
\wedge	ath with the Marylan 23a or 28a-f show ast be mulfiled at		10e. Street and Nu					10f. Zip Code					Citizen of What	Country	y :
6		Funeral	11. Marital Status	Mohr Roa	12. Was Dece	dent Ever in U.	.S. 13.	2108 Was Decedent of		Origin? (Sp	ecify Yes or N		U.S.A.	merica	n Indian.
,	- ± €			ried 2 Married	Armed For d 1 ☐ Yes	ces? 2 ™ No		Was Decedent of If Yes, specify C			Rican, etc.)		Black, W		
2009	72 hours after natural", or ite	by	3 X Widowed	4 Divorced	If Yes, Giv Year or Da	e tes:		1 □Yes 2XIN	lo Speci	ty:			Specify: V	Vhit	e
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95	within ene.	Completed	Elementary/Seco		College (1-	4or 5+)			ired)			Ι.	O II		
		ပြိ	12 17. Father's Name	(First, Middle, La	est)		HO	memaker_	18. Mo	ther's Name	e (First, Middle		Own Hor	ne .	
20	d be i ental ced o	o Be										,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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3 3	ine, intally lattice, and 2 stand 2 stand 2 should be filed within 72 ho of Health and Mental Hygene, item 27 is marked other than "nature other traumatic event, the medical contents."		Steven	Panzer	(son)		2 Pi	ne Lane	Court	- Do	uqlasvi	lle	, Penns	svlv	ania 19578
5	of He		20a. Method of Dis	sposition		20b. F		osition (Name of ematory or other p			Date		Location - City		
ebrua	Pages ment of ant: If its ury or o			5 ☐ Other (Spe	☐Removal from S cify)	Pa		d Cemete			3/2009				aryland
February 19	partition of your permit. Pages 1 an Department of Heal Important; if item 2 any injury or other once.		21. Signature of Fi	uneral Service Lic	censee										ome, P.A.
0.0	T 90 = 40		70.	J. X	assal	S							le, Mai	_	nd 21087
D.C.		ı	23a. Part 1. Enter	the disease, or co art failure. List on	omplications that cally one cally on ea	used the deat ich line.	h. Do not er		dying, such	as cardiac	or respiratory	arrest,		ĺ	Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	-a Kuf	ture	d he	patie	CAN	sun	um				Onset and Death
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		늘	Sequentially list contains to include Enter Under Cause (Disease or	onditions,	b. Due to (c	Fas a sunseq	uence ur;					_			
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68760	Attending Physician: The law requires that the death certificate be executed refeath. Sector: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	edical			d									-	
	Se as		IF FEMALE:		23c. If yes, outo	ome of pream	ancy								
Box	eath certifi attending for use as	Physician/M	23b. Was deceden	2 months?	1 Live b	irth 2 ☐ Feta ant at time of o	ıl death 3	☐ Ectopic pregna					23d. Date of Month		/ ay Year
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Δ,	s that med b	by P	Part II. Other signi	ficant conditions	s contributing to dea	ath but not res	ulting in the i	underlying cause	given in Par	rt I.	23e. Did	tobacco	use contribut	e to the	cause of death?
Bocorde	w requires been signature should by	ed b									1 🗆	Yes 2	2 □ No 3 □] Probat	oly 4 Unknown
779	law re as be 2 sho	Completed									24a. Was				y findings available bletion of cause of
9	The ate h	E O									perf 1 □ Yes	ormed? 2 N	deat	h? Yes 2	
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laral	ding Physician: The law h. After this certificate has funeral director, page 2 s		1 ☐ Yes 2 2		Hospital: 12 Ir	patient 2	ER/Outpatie	ML 3 L DOA			me 5 Res			Specify)	
	dlng h. After funer	tion	1 Natural	5 Pending investigat	(Month	n, Day, Year)	Injury	W	njuryat √ork? □Yes 2 l		28d. Describe	now inju	ury occurred		
ter (Attend	fica	2 ☐ Accident 3 ☐ Suicide	6 Could not	be 28e. Place of	of Injury - At he	ome, farm, st	reet, factory, offic						r Rural F	Route Number,
726 Divid	al or safter	Certification: To	4 Homicide	determine	buildin	g, etc. (Specif	<i>y)</i>				City or To	wn, Sta	te)		
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0	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medical	one)	4	and mann	er stated.									· · · · · · · · · · · · · · · · · · ·
	5 ≰ 7 © oo 1	-	29b. Signature and	Tutle of certifier	a Or	2 2000	01.0	- 29c. Lice	ense numbe	F1/.		29a. D	ate signed (M	onin, Da	ay, rear)
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	Sta	ate	31. Date filed (Mor	nth, Day, Year)	322 Re	gistrer's Signa	iture—	a cru	Supe		11:4				0101
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Edward 8:55 AM M February /Medical 15 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6123 Parkway Drive Baltimore Baltimore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 125M 2□F Yrs. 216-48-1611 Director 61 12/31/1947 MD Usual Residence of Decedent death with the Maryland I Hygiene. other than "natural" or items 23a or 28a-f show vent, the Modical Expanser must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ⊠Yes 2 No Director MD Baltimore City Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 6123 Parkway Drive 21212 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, Ite Medical Exemina 1 Never Married 2 Married 1 □Yes 2 No 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Furniture Refinishing Elementary/Secondary (0-12) College (1-4or 5+) Self_Employed Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edward Emmett Pooley Sr. Denise J. Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Dartmouth Road Baltimore, MD 21212 Sarah Pooley/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 17 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 Beltsville, Maryland Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 18717 - Groon Pastures Drive Baltimore, ter the mode of dying, such as cardiac or respiratory arrest, and provide the linterval Between Onset and Death **Physician** disease or condition resulting in death) Metastat /Medical Due to (or as a consequence of): **Examiner** Securifially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Division of Vital Records, P/O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 1 ☐ Yes 2 ☐ No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital (a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinoie, 40. 2120 Couling -Brown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01275 State of Maryland / Department of Health and Mental Hygiene Spero Peratino 2009 05226 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Month Day February 12, 2009 Physician/ 0855 hrs Medical Examiner Spero Peratino 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Potomac 1297 Bartonshire Way 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Hours Months Days Country) DC Sept. 10, 1952 Director 1 X M 2 56 212-64-1269 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 Yes 2 X No Potomac Maryland | Montgomery with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 20854 1297 Bartonshire Way 14. Race - American Indian, Black, Permit. Pages 1 and 2 should be filled within 72 hours after death with repertment of Health and Mental Hygiene.

**Propriettien 27 is marked other urg or other frame. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married Yes 2 X No Specify: White Yes 2 X No specify: If Yes, Give Year Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) Retail Grocery Food/Beverage Sales 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olga Frangos Be Petro Peratino (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 14917 Finegan Farm Drive, Darnestown, MD 20874 MaryAnn P. Jobe/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Feb. 19, 2009 Bethesda, Maryland Donation 5 Other Specify 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee 711W M01548 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - tran 23a,2/,perME, g889 3/6/09 TT Physician/Medical X UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte I be detached for u 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. No 3 Probably 4 ✔ Unknown Yes 2 ğ Completed 24b. Were autopsy findings available s certificate has been si rector, page 2 should b 24a, Was an prior to completion of cause of autopsy performed? death? No 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica funeral director, Division of Vital Be Other-Hospital: Residence 6 V Other: Scene examiner? Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 1 X Natural Pending 24 hours after death. the Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 13, 2009 O.C.M.E.

7 pers

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

2. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2 0 2000

Ana Rubio MD.

31. Date filed Month, Day, Year,

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 23a, 26 per doc 8888 2-25-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Month 2089 7:10 **Physician** ohn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Ballinous Rehabilitation Extended Care Cen NA Balto 8. Date of Birth (Month, Day, Year) 3-11-1943 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 65 N.C. 216-42-5716 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprintment and the notified at once. 1 XYes 2 ☐ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 USA Preston Street 2600 E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Black 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled N/A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Ann Stubbs James E. Ray, ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 E. Pine Delmar, MD 21875 Troy Ray-Son 25 Date 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD -2009 Owings Mills, $2 - \frac{24}{}$ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 lon ane 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ostate Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fix as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. \$ 24 hours after death.

Funeral Director: After this certificate has been signietely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 MNo 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specific 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOVER E. WIKS IM MD. 3900 Loch Raven Boulevard Battimore, Maryland 21218 Jeorge E 32 Registrar's Signature 31. Date filed (Month, Bay, Year) State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** RYBCZYNSKT GARY 2009 5.06AM 3 EDMA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Howard County General Hospital** Columbia Howard Date of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2 □ F Months 219.44.9650 Director 63 MD Sep 12, 1945 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits rd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Howard **Ellicott City** 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 8479 Timberland Circle 21043 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 1 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Abstractor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H item 27 is marked oth other traumatic even Be Melvin John Rybczynski Lillian Mildred Frejka ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Gary Rybczynski - Son permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 5010 Finsbury Road Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 15, 2009 Atlantic Crematory, LLC Glen Burnie, MD Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1400536 20a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Athenoselerotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consumeror off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Describing the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2009 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia WALTER ATHA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28d per ME g889 3/10/09 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Catherine T. Rosen 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Roseda Franklin Square
5. Social Security Number 6. Se 140501 ta Himore le Da 8. Date of Birth Sept. Day Year 1910 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 217-03- 8991 1□M 2□F Months Days Hours Min. 98 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ns 23a or 28a-f show must be notified at MIddle River 1 ☐Yes 2 No Baltimore MD Director death with the 10f. Zip Code 21220 10e. Street and Number 10g. Citizen of What Country? 503 Grovethorn Road USA Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status Black, White, etc. "natural", or iten permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Ackerman Matilda C. Kriss P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Wolfe /daughter 2115 Sunnythorn Road Baltimore MD 21220 Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/21/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Service Licensee MD Connelly Funeral HOme of Essex 21221 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iomplications **Physician** Multin druss disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner hip tractu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTN BreasT 1 □ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HearT has autopsy performed page 2 certificate 1 ☐ Yes 2 ☐ No 2 1 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 pnpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Subject fell 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 9:00 A and was later 2//6/09 9:00 A M 1 = 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No investigation 2 Accident subject was given errant medications filled in by the 6 Could not be determined 3 ☐ Suicide 281. Cation (Stre. t and Number or Rural Route Number, 2/23) City or Town, State) 4 Homicide 9200 Franklin Square Drive Rospfafe ranklin Woods Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred of the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/17/2009

State

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

or Vital Records,

Division

1050

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Anne

31. Date files (Month: Day, Year)

FFR 2 0 2009

Franklin

32. Registrar's Signature

E300000

Drive Baltimore, ND 2/237

Registral
DHMH 17 Rev 1/2001
OCME 2006

State

31. Date filed (N

ORIGINAL

parke

Registrar's Signature

OCME

State of Maryland / Department of Health and Mental Hygien 9 \cap \cap Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Maurice Smit th 2009 9:15 PM February 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **Baltimore** Randalistown Genesis Eldercare-Randallstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 13, 1934 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 216-32-2798 **Director** 74 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatith and Mental Hygiene.

Int: If Item 27 is marked other than "neturel", or items 23e or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or items 23e or 28a-f show the Medical Examiner rust be mailfied at 1X Yes 2 No Woodlawn Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Derbyshire Circle 21244 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Port City Press Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary F. Smith Morris A. Smith treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Waters 3503 Derbyshire Circle Windsor Mill, Maryland 21244 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o importent: If eny injury or once. injury or 02/21/09 Catonsville, Maryland * 4 Demation 5 Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral ervice Ligensee 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final ST elevation myocardial Non **Physician** infarction disease or condition resulting in death) /Medical Examiner disease artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine vascular disease the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed sheral Severe Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown nas been signed by the e 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Kena Sta ausease 2 No 3 Probably 4 □Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physicien: Viting the recent within 24 hours effer death.

To the Funerel Director: After this certification of the Funeral director, when the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16th 2009 D0058965 Februan Khowal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road KHAWAJA Kandall 31. Date filed (Month, Day,-Year) _____ 32. Registrar's Signature State Registrar 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FS R Year Physician 7120 AM SITUEN BSRGSR 020262 CHRISTIAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☑ M 2 ☐ F 200-20-4669 Oct.2, 1927 Director Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Maryland Howard Ellicott City 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 10323 Burnside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Defense 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Emil Martin Shoenberger Martha Thumm ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. Wife 10323 Burnside Drive; Ellicott City, MD 21042 Josephine Shoenberger 20c. Location - City or Town, State 20a. Method of Disposition Date Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2/21/2009 Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER MOS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1∐Yes 2.121No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □Yes 2 DNO 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 SCHAEFER ME FDWARD w. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Voar **Physician** Donald A. Shannon Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FLAIR HERETHAND BEHABILITATION CENTER ORI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-07-1929 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X**☐ M 2☐ F 80 215-28-4262 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Director 1 ☐Yes 2 No MD Harford BeL Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? · death v 800 Candlelight Dr Apt 1C 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black. White, etc. filed within 72 hours after 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver brake shoe lining co. permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygis Important: If Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald A. Shannon Sr Sue G. Hummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Shannon (Wife) 800 Candlelight Drive BelAir, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ě Injury Bel Air Mem. Gardens 02-20-2009 Bel Air, MD 22. Name and Address of FacilitySchimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEGUOVEG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner s a consequence of): certificate be executed and Due to (or as a consequence of): physician Physician/Medical as attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an certificate has autopsy performed Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After the Hospital or Attending hin 24 hours after death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛚 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

1308 (gusus

ORIGINAL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g888 2-25-09 vr. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 05234 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 200 G **Physician** erome 51 AM er /Medical 4c. County of Death Name (If not institution, give st 4b. City, Town, or Location of Death Examiner Baltimore
Baltimore edica ent ŧ 5α ナ Ore If Under 24 Hrs 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday, Birthplace (State or Foreign **Funeral** Days Months Min. Hours -1932 76 Director MD 215-28-3330 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov Examiner must be notified at MD 1xXYes 2 □ No N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21st Street 21218 324 E. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar, or items 23a any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must gonee. US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. MXYes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Specify: Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Towson Orthopedic Elementary/Secondary (0-12) College (1-4or 5+) Orthopedic Assistant llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Carr ပ Oliver Stern, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 19a. Informant's Name/Relationship (Type. Print) Shirley Davis-Daughter <u> 201</u> Patterson Park Avenue BALTIMORE, MD N. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cem 2-23-09 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Jan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Avenue Balto, MD 21202 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** End stage Chronic obstructive /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burla Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 1□ Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this s after death.
ral Director: After th 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435A18120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Greene Street Baltimore, MD 21201 10 rimberle 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 0 2009 acked Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** FEB 13, 9:10 p м Dorothy M. Stickman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fairland Nursing Home 2101 Fairland Silver Spring Montgomery 8. Date of Birth Month, Day, AUG 31, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🙀 F Min ^Y1915 Pennsylvania **Director** 168-22-8743 93 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 556 Whispering Meadows Dr. 21158 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X**☐ No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edward Parmeter Viola Mae Straight ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Digel/Daughter 556 Whispering Meadows Drive, Westminster, MD 21158 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 2/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 22. Name and Address of Facility Rapp Funeral & Cremation Services 935 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED **Physician** DEMENITIA 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed burial-trans and Due to (or as a consequence of) physician Physician/Medical the attending p for use as use as IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed CARDIOVASCULAR ERGTIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate ! meg / 2 No 1 TYes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tyes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bhrs

MASSI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15225 SHABY GROVE

Registrar's Signature

29d. Date signed (Month, Day, Year)

2009

			for State Of Mal State Registrar	ryland / Depa <i>Cel</i>	artment of F rtificate of I				nq	05236
	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death
	Physici /Medic		William Anth	ony Shade			Month Februai		Year 1009	12:05PM M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			194 Leland Street 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	Rockville If Under 24 Hrs.]	Monts	gomery place (State or Foreign
	Funeral Director		1X M 2 □ F	59 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day February	Year)	Coun	ntry)
	D		Usual Residence of Decedent		<u></u>		rebruary	23, 1949	V.	irginia
	arylar show	_	10a. State 10b. County	10c. City, Town or Lo	ecation				1	0d. Inside City Limits
	28a-f	Director	Maryland Montgomery			lockville				1 X Yes 2 □ No
	a or		10e. Street and Number		10f. Zip Code			10g. Citizen of W	/hat Coun	ntry?
	ns 23	Funeral	194 Leland Street 11. Marital Status 12. Was Decedent Ev	ver in U.S. 13	Was Decedent of H	20850	ecify Yes or No.			States can Indian,
٥	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Evan for mut be inciffed at		Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No	,	Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Blac	k, White,	
5-0036	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1⊡Yes 21∏ No	Specify:		Specify		White
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7	within 72 iene. than "nai	dm	Elementary/Secondary (0-12) College (1-4or 5+)) life. I	DO NOT use retired	1)		Media		
V	be filed valued Hygis	e C	17. Father's Name (First, Middle, Last)	Const	ultant	18. Mother's Name	e (First, Middle.		e)	
/land		To B	James R. Shade, Jr.			Anna Ta	,		-/	
ar <	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			er, City or Town,	State, Ziç	Code)
, ⊠	and 2 saith a n 27 is er tra		Robert James Shade/ Brother		Nathan					
o G	of He of He fiten		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer Montgome	sition (Name of matory or other place	[Date	20c. Location -		
Ě	Pag ment lant: I		4 □ Donation 5 □ Other (Specify)	Cremator	ium Inc.	18.	ruary 2009	Bethes	da.	Maryland
Baitimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enge.		21. Signature of Funeral Service Licensee	22 F	2. Name and Addres	ss of Facility Rob	ert A	Piimphras	7 Finn	aral Homa/
	424.0				Rockville Rockville				-17 1	
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List on the cause on each line. Immediate Cause (Final			ig, sucri as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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and the same	Examiner			consequence of):						
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POX	eath atter for u	Physician/N	in the past 12 months?	Fetal death 3	Ctopic pregnancy Other (specify)	у		23d. Dat	e of delive nth	Day Year
j.	the c	nysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at til 9 ☐ Unknown 9 ☐ Unknown	J.						
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	The sate h	Completed					autop perfor 1 □ Yes	med? d	leath? Yes	mpletion of cause of
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5	ding h. After funer	tion	27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day,		Work		28d. Describe h	ow injury occurre	∌d	
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5	al or safter	Certification:	4 ☐ Homicide determined 200. Flace of Injury building, etc.	y - At home, farm, str (Specify)	oot, idotory, omoo		City or Tow	n, State)	n oi Huia	ir Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	my knowledge, death	h occurred at the tir	ne, date and place,	and due to the	cause(s) and ma	nner as s	tated.
	the P thin 24 the F mplete	Medical	one) and manner state 29b. Signature and title of certifier , "	ed.						
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			30. Name and address of person who completed cause of dea	THE OTHER 2201 /Tim-	D0027	985		Febru	ıary	16, 2009
				201 Seven	,	ad. Rocks	7ille. M	[arvland	2081	54
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Ma		ertificate of Dea	ath	Reg. No. 200	9 05237
	Physici		1. Decedent's Name (First, Middle, Last) Ressie Co	ecelia Sud	er	2. Date of Month	Day Ye	ar 3. Time of Death
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or Loca	ation of Death	4c. County of D	12.0011
			Memorial Hospital 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday	Cumber If Under 1 Year If U	Jnder 24 Hrs. 8 Date of	HILEG	GNY Birthplata (State or Famign
ŀ	Funeral Director			81 Yrs.	/	ours Min. (Month 01/1	Birth (Day, Year) (9.17/1928	Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
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	with th	Dire	10e. Street and Number		10f. Zip Code	20	10g. Citizen of What	
	ms 23	nera	749 Narrow Lane 11. Marital Status 12. Was Decedent	Ever in U.S. 13.	1552 Was Decedent of Hispan	AZ nic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No- 14. Race - A	merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examina.	Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Signify Sign	No		exican, Puerto Rican, etc. pecify:) Black, W Specify:	White, etc. White
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Maryland	id 2 sho Ith and 27 is ma		19a. Informant's Name/Relationship (Type. Print) Edith Johnson / Daughter		ing Address <i>(Street and I</i> Bristol Aven	Number or Rural Route Nu use Balti	imber, City or Town, Stat L ${ t more, Mary 1}$	
re,	es 1 and 2 of Health filtem 27 r other tr		20a. Method of Disposition		osition (Name of ematory or other place)	Date	20c. Location - City	
Baltimore,	Pages ment of tant: If It tant: If It luy or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Glen Hav	en Mem. Parl	k 02/19/200	9 Glen Bur	nie, Maryland
Ball	permit. Pag Department Important: I any injury o		21. Signatere of Funeral Service Licensee		22. Name and Address of 4001 Ritchie	GOILCE	uneral Servi altimore, Ma	ice, P.A. aryland 21225
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	the death. Do not enne.	nter the mode of dying, su	ich as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death
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Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification: To	datermined 200. Place of Inju	ury - At home, farm, si c. <i>(Specify)</i>	treet, factory, office	28f. Locatio City or	on (Street and Number or Town, State)	r Rural Route Number,
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or i	ath occurred at the time, d investigation, in my opinio	late and place, and due to n, death occurred at the ti	the cause(s) and manne me, date and place, and	r as stated. due to the cause(s)
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			ON Name and address	least (ltr. 200) 77	02337		1-631	1,2009
4	\		30. Name and address of person who completed cause of d	U 600 I	Momaial A	1 1 Avenue Cun	healand ,	MD
	Sta		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	a Kel			
	Registr	ar	FEB 2 0 2009 Amer	as por the	Story and			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05238 Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEV SPIVAK **FEBRUARY** 2:45 P 17, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Yrs. Director 08/14/1924 213-37-2244 UKRAINE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ire Medical Expression is ust be notified at Director 1 □Yes 🌠 □ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD, #405 21208 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE \$ Specify 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CIVIL ENGINEER CONSTRUCTION permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy, important: If item 27 is marked any Injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YAKOV SPIVAK TDA မ ROIDMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>LYUBOV SPIVAK / WIFE</u> BALTIMORE, MD 21208 <u>16 OLD COURT ROAD, #405</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM.02/19/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Melt 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between (end-stage Onset and Death Immediate Cause (Final CardiomyopaThy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury ē Due to (or as a consequence of) Examir The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. ed by the a detached f TYes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy 1 □ Yes 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 5 Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) HOSPICE 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 2/18/09

State Registrar

DHMH 17 Rev 1/2001

25 Main St., Suite

32. Registrar's Signature

ZOU,

Reistersionn, MO. 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Kajapakie

Year

31. Date filed (Month, Day,

		1 - State of Ma Registrar		artment of Healt ctificate of Dea		ntal Hygien Reg. N	711114	05239
Physic /Med		Decedent's Name (First, Middle, Last) MELVIN SHILLING	<u> </u>				ay Year 17, 2009	3. Time of Death
Exam		4a. Facility Name (If not institution, give street and number) GILCHRIST HOSPICE CARE		4b. City, Town, or Locat			c. County of Death BALTIMOR	ιE
Funera Directo		119-22-0459 ¹♥™ ²□F	(In yrs. last birthday) 78 Yrs.	If Under 1 Year If Un Months Days Hou	urs Min.	Date of Birth (Month, Day, Year 0/02/1930	9. Birthp Coui	place (State or Foreign ntry) NY
Maryland f show	tor	Usual Residence of Decedent	10c. City, Town or Lo				1	10d. Inside City Limits 1 □Yes 🙀 □ No
with the I	Funeral Director	10e. Street and Number 4304 SCOTCH ROSE COURT	DALTI	10f. Zip Code 21208		10g. C	itizen of What Cour	
rs after death	by Funera	11. Marital Status 1 Never Married Married 12. Was Decedent Event Armed Forces? 1 Yes 2 No liYes, Give 3 Widowed 4 Divorced Year or Dates:	,	Was Decedent of Hispanio f Yes, specify Cuban, Mex	c Origin? (Speci xican, Puerto Ric ecify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
If and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hodien Event" are must be notified.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during OO NOT use retired) HARMACIST	most of working	16b. I	Kind of Business/In	•
lal ylallu ZIZI 2 should be filed within and Mental Hygiene. is marked other than 'a aumatic event, the 'm'	To Be Co	17. Father's Name (First, Middle, Last) IRVING SHILLI			Nother's Name (F	First, Middle, Maide		
Te, Malyla 1 and 2 should I Health and Men tem 27 is marke		19a. Informant's Name/Relationship (Type. Print) BARBARA SHILLING / WIFE		g Address (Street and No		Route Number, City		,
Page nent c		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispor- cemetery, cren BETH EL M	sition (Name of natory or other place) EMORIAL PARI	Z/19/2		Location - City or To	
parit. Departit. Departit Imports any Inj		11. Signature of Funeral Service Licenses		Name and Address of F			& BROS., VILLE, MD	
Physician		resulting in death)		er the mode of dying, such				Approximate Interval Between Onset and Death
e be executed sician and purial-transit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c	consequence of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknow	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
quires that n signed build be deta	þ	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in P	Part I.		use contribute to the	he cause of death?
The law requested has been a should be a s	Completed					24a. Was an autopsy performed? 1 ∐Yes 2 N	prior to co death?	ppsy findings available impletion of cause of 2 No
ding Physician: The Indian Physician: The Indian Physician: The Indian Physician Indian Physician tion: To Be	27. Manner of Leath 128a. Date of Injury (Month, Day,	t 2 ER/Outpatien (28b. Time of Injury	t 3 DOA Other: 4	280		6 Dother (Specificary occurred	»ho≥piû	
al or Atten s after deat I Director: ed in by the	Certification:	a Cuiside 6 Could not be	y - At home, farm, stre (Specify)			Location (Street a City or Town, Stat	and Number or Rura te)	al Route Number,
he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one one of the best of and manner state.	examination and/or inv	n occurred at the time, day vestigation, in my opinion,	te and place, and , death occurred	d due to the cause(at the time, date ar	(s) and manner as s	stated. o the cause(s)
To t with To t	M	29b. Signature and title of certifier		29c. License numb	303	29d. D.	ate signed (Month,	Day, Year)
10 1		30. Name and address of person who completed cause of dea	1 6701 N	. ^ /	ST 1	wew o	ND Z	1204
Si Regis	tate trar	31. Date filed (Month, Day, Year) 32. Ragistrar	's Signature	a del				

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Ustown 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 🔏 🗆 F Months Hours Director 226-34-3050 Jan 27, 1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10h County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 616 Archer Street 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Richard Grandy Moriah Grandy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau once. 635 Augusta Avenue Baltimore, Maryland 21229 Sheila Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 02/20/09 4 Donation Cedar Hill Cemetery & Mausoléum 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death. and burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) <u>Ч</u> 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an has autopsy performe After this certificate 2 NO 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 1 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Attatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

X□Yes 2□No

Virginia

U.S.A.

Specify:

14. Race - American Indian, Black, White, etc.

Own Home

Brooklyn Park, Md.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Month

Black

address of person who completed cause of death (Hem 23a) 31. Date filed (Month, Day, State

and manner stated.

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature and title of certifier

Medical

completely

To the I

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			1 – For State Registrar		Maryland / D	epartr		lealth and	Mental Hyg			052	241
	Physici	an	1. Decedent's Name (First, Middle,	·					2. Date of Dear	Day	Year	3. Time of	
Ì	/Medic Examin		Martha May 7 4a. Facility Name (If not institution, 8606 Midi Ave	give street and number	er)	4b.	City, Town, or Parkv	Location of Deal	February h		2009 nty of Death imore	3:30	РМ
	Funeral Director		5. Social Security Number 168-24-8196 Usual Residence of Decedent	5. Sex 1 □ M 2 💢 F	Age (In yrs. last birti		Under 1 Year onths Days	If Under 24 Hrs Hours Min.		Year) 28	9. Birthpl Count Pitts	ace (State o ry) urgh, l	r Foreign
	Maryland a-f show	tor	10a. State 10b. County MD Balti	more	10c. City, Town		n				10	ld. Inside Cit	
:	th with the 23a or 28a	Funeral Director	10e. Street and Number 8606 Midi Ave	nue		10	of. Zip Code 21234	*	1	0g. Citizen o	of What Count	ry?	
5-0036	perfilm: Fages 1 and 2 should be filed within 72 hours after death with the Maryland gradument of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventies and the notified a sonce.	þ	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force d 1 [Yes 2] If Yes, Give Year or Dates	s?] No	_	Decedent of Hi , specify Cubar es 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	В	Race - America Black, White, el cify: Whit	c.	
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yland	Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, La Roy Byron Fink						ne (First, Middle, M May Vette		ame)		
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baltimore	tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	20b. Place of least permetery Dulane Memori	y cremator Y Va al G	y or other place Liley Lardens	2/2	0/09	Timoni	n - City or Tow um, MD		
מ	Depar Impor any Ir		21. Signature of Funeral Service Li	Delva	MO	Ê√a 880	ns Fur O Hari	neral c ford Rd	hapel & Ci Parkvil	Le, M)	n Servi 21234	œs	
	hysician /Medical xaminer		23a. Part 1. Enter the risease, or or shock, or heart Fillure. List or immediate Cause Final disease or condition resulting in death)	a.	line.	NIC			Lung			Approximate Interval Betw Onset and D	veen
		l Examiner	Sequentially list conditions, if any had not be immediated cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	is a consequence of								
the death certificate	or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death at time of death		opic pregnancy er (specify)				Date of deliver Month E		ear
outres the	en signed by the a	þ	Part II. Other significant condition	s contributing to death	but not resulting in t	the underly	ring cause give	n in Part I.			ntribute to the 3 ☐ Proba		
Idi nece	tificate has be or, page 2 sho	e Completed	25. Was case referred to medical	T .						y ned? XNo	o. Were autops prior to com death? 1 □ Yes 2	pletion of ca	vailable use of
Physick	h. After this certificate h. funeral director, page	n: To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of In		me of	DOA Other	r: 4 🗆 Nursing H	th (Check only one ome 5 \ Reside Reside 18d. Describe ho	nce 6 □O			
or Attending	atter death. Director: Aft in by the fun	Certification	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Ir	njury - At home, farn	ury M n, street, fa		es 2 □No	28f. Location (Str. City or Town	eet and Nun		Route Numb	er,
le Hospital	in 24 hours he Funeral pletely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the bes aminer: On the basis and manners	of examination and	death occu or investig	urred at the time ation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	ause(s) and a	manner as sta e, and due to t	ted. ne cause(s)	
Jo E	To t.		29b. Signature and title of certifier	LAS	7		29c. License	number			ned (Month, Da		
	- CA-		30. Name and address of persol whe LAWFENCE 31. Date filed (Month, Day, Year)	BOASA	death (Item 23a) (To	ype, Print)	077 A	DAM R.	D CECK	EUSVIL	E, M	D 210	30
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State of Maryland / Department of Health and Mental Hygiene 05242 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:45AM Kobenia INNIN 02 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖫 F Months Days Hours Min. 213-30-3381 Director 07/18/1933 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Modical Examinar must be notified at once. 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County Director **Baltimore** 1 X Yes 2 ☐ No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1114 Cherry Hill Road 21225 Apt. D U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Benefit Authorizer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza Ehoch 2 Robert E. Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Cherry Hill Rd., Baltimore, Maryland 21225
ace of Disposition (Name of Date 20c. Location - City or Town, State Robyn R. Bolling / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/23/2009 Lansdowne, Maryland Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebrow **Physician** hours. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 months hromboc4topenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transi The law requires that the death certificate be execute Box 68760. nding physiciar Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atter 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ∐Yes 2 X No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Breast cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate 2 No 1 □Yes or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 121202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene M. Kin Street Baltimore M.D. Begistrar's Signature 31. Date filed (Month, Day, Year) 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2/16/2009 2100 RUBY THORNTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🕅 F 12/18/1927 Washington, 81 Director 578-36-9191 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20009 United States 2801 14th St. NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2√∑No Specify: Black. Specify: þ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government 12 General Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked oth traumatic ever 1 and 2 should be William Crockett Lillie Crawford ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Anne Yarber / Sister 1115 Anacostia Rd. SE Washington, D.C. 20019 If item 27 or other t Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Lincoln Memorial 2/23/2009 Suitland, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Lice Fee 181082 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) +cute myourdied **Physician** /Medical Due to (or as a consequence of): Examiner Atherocciemne cure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans requires that the death certificate be execu-Due to (or as a consequence of): Box 68760. Physician/Medical attending pl for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) I ☐Yes 2 ☐ No signed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 bn 10 24a. Was an page 2 s Jas performed? Yes 2 No certificate SCVEVE 1 ☐ Yes 2 ☑ No anemia 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 ☐ Yes 2 WNo ٩ 1 ☐ Inpatient 2 ☐ ★ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after in 24 hour. the Funeral Dire 1 7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Mom D50689-30. Name and address of person who completed cause of death (Item 23a) Type, Print) ANTLE MATTER OF MO SUNTRONA MANIAND HOSPITER Center 7503 Surate Rd Clinton and 20735 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 05244 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Fe.b. Day 2009 **Physician** 9:42 PM Hoover Thompson 16 Alfred /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Levindale Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07 16 28 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 **→**M 2 □ F Months Hours Director 80 NC 239-32-8833 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f shov Examiner πust be notified at MD NA Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2801 Windsor Ave Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1♥]Yes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes ¾☐ No Specify: Baltimore, Maryland 21215-0036 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) M.T.A. Bus Driver 2th grade 4yrs or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Estella McKellar James Thompson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28205 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 1505 East Crest Drive Apt T-1, Charlotte, Deloris Floyd-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 2/24/09 Owings Mills, 21 Signature of Juneral Service Licensee 22. Name and Address of Facil March F/H West 300 Wabash Ave, Baltimore, Md 21215 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Coronary event 30 min. /Medical Due to (or as a consequence of): Examiner 6 months coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ failure 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed Philmonary ease 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🕱 No 24a. Was an autopsy certificate 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. neral Director: A To the Hospital of within 24 hours at To the Funeral D

1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

02/16/2009

D0053928

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA 2434 W. BELVEDERE AVENUE, AALTIMA BEWUM, MD - 21215 BALTIMORE

Registrar

Medical

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:44a M John Junius Talman III February17,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 77 213-30-1807 May 8, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r items 23a or 28a-f shov inscreast be rofffied at 1 Yes 2 □ No Annapolis Director Anne Arundel MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21401 by Funeral 130 Hearne Road death 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Air Force 1 ☐Yes 2X No Specify: Specify: White event, the Medical Exar. 3 ☐ Widowed 4 ♣ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Government Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Photographer permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If Item 27 is marked other the any injury or other traumatic event, Item 20nes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Junius Talman Jr. Bettie G. Motague ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Junius Talman IV / Son 1202 Marda Lane, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/18/2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall Mar Duell PO Box 1413, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Month in the past 12 months? Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1. Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 ☑No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Ne Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Aftetely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier OC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Day, Year) Registrar's Signature State Farks Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar				Ce	rtifica	te of	Death		eg. 140.	2009	05246
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Funeral Director		078-07-7123	11		93		Months		Hours Min.	8. Date of Birth (Month, Day)	Year) 1915	Cour	place (State or Foreign htry)
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a or 26	Funeral Director	10e. Street and Number 3303 BEN	VALLEY	ROAD			10f. Z	ip Code	21244	1	0g. Citizer	n of What Cour	ntry?
death	iner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dec	edent of F	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14.	Race - Americ	can Indian,
Irs a	2	1 ☐ Never Married 2 3 🏹 Widowed 4 🗆 D		1 ∐Yes 2 📉 If Yes, Give Year or Dates:	No		1 □Yes		Specify:	7 110411, 010.7	Sp	pecify: WHI	
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permi Depar Impor any ir		21. Signature of Funeral	Service Licen	111001		1			ess of Facility SC TERSTOWN	L LEVINS			
		23a. Part 1. Enter the disc shock, or heart failu	ease, or comp	JWY C	d the death							VILLE	Approximate Interval Between
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/Medical Examiner		resulting in death)		Due to (or as									
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t the d by the tached	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unknown		J.		specify/ _					
uires tha signed Id be dei	ል	Part II. Other significant	conditions co	ontributing to death b	ut not resu	ulting in the u	underlying	cause giv	en in Part I.				ne cause of death?
aw req as beer 2 shou	plete									24a. Was a		24b. Were auto	psy findings available
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g Physer this eral di	0: I	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	ıry	28b. Time of		28c. Inju	4 LI Nursing H	ome 5 ☐ Reside		Other (Special	30-110-
eath. or: Aft the fun	catio	2 Accident	Pending investigation Could not be	1	iy, rear)	Injury	М		k? Yes 2 □ No				-
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of in building, el	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, facto	ry, office		28f. Location (S. City or Town		Number or Rura	al Route Number,
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To the within com	Ž	29b. Signature and title of	f certifier	2 ton			2		se number			signed (Month,	
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DHMH 17 Rev 1/2001

		,	1 - For State of Maryland State of Maryland	/ Depa	artment of F	lealth and Death		ene g. No. 2009	05247
	Physici		Decedent's Name (First, Middle, Last) Carrie Leona Vonberg				2. Date of Death Month Feb 18,		3. Time of Death 7:45 P M
3	/Medio Examir		4a. Facility Name (If not institution, give street and number) Marley Neck Health & Rehab		4b. City, Town, o			4c. County of Dea	
ř	Funeral Director		5. Social Security Number 170-52-7746 6. Sex 1 ☐ M 2 XXF 89	t birthday) Yrs.	If Under 1 Year Months Days		B. Date of Birth (Month, Day, Feb 16, 1	9. Bi 920	rthplace (State or Foreign country) PA
	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7 MD Anne Arundel Glen	Fown or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What C	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exeminer must be notified at	by Funeral	7575 E. Howard Rd 11. Marital Status 1 □ Never Married 2 □ Married 3\\(\text{\text{\$\infty}}\) Nidowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ X\(\text{\text{\$\infty}}\) Nidowed 1 □ Pates:	'	21060 Was Decedent of H If Yes, specify Cub. 1 □ Yes 2 □ No	lispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	14. Race - Am Black, Whi	erican Indian, ite, etc.
Baltimore, Maryland 21215-0036	I within 72 hou piene. r than "natur the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give life. i	dent's Usual Occup kind of work done DO NOT use retired emaker	durina most of v	working 1	6b. Kind of Business Own Home	s/Industry
yland 2	12 should be filed w h and Mental Hygie 7 Is marked other t traumatic event, th	To Be C	17. Father's Name (<i>First, Middle, Last</i>) John T. Huston			Margare	Name <i>(First, Middle, Ma</i> t K. Spauldin	g	
, Mar	and 2 sh salth and 1 27 Is m er traum		19a. Informant's Name/Relationship (Type. Print) Tammy Craig				Rural Route Number, urnie, MD 210		Zip Code)
more	Pages 1 sent of He nt; If item		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State cen	netery, cren	sition (Name of natory or other place 11s Mem. Pl	i i		oc. Location - City of chester, PA	r Town, State
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once.		21. Signature of Fineral Service Liop/See K. Gregory Fink M01148		2. Name and Addre Fink Funer	ss of Facility al Home,			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. shock, or peart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	eil	M. E. Sanctinan	lg, such as card		st,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Line: Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of consequence).	nce of):				140	
c 68760,	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d						
.O. Box	the death certific by the attending p ached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 mooms? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify) _			23d. Date of de Month	elivery Day Year
Records, P.	w requires that the de been signed by the a should be detached t	ρχ	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause giv	en in Part I.			o the cause of death?
al Reco		Completed					24a. Was an autopsy performe 1☐ Yes 2	ed? prior to death?	utopsy findings available completion of cause of
Vital	ysiciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6 Hospital: 1 ☐ Inpatient 2 ☐ ER	l/Outnatien	t 3 DOA Oth	ar:	Death <i>(Check only one)</i> g Home 5 ☐ Residen	as 6 DOthor (Sa	noif ()
on or	ding Physician: The h. After this certificate ha funeral director, page	tion: To	27. Manner of Teath Natural 5 Pending (Month, Day Year) 28	Bb. Time of Injury	28c. Injur Wor		28d. Describe how		ecity)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre		100 2 110	28f. Location (Stre City or Town,	et and Number or R State)	tural Route Number,
	le Hospital 24 hours a le Funeral I	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the cau ccurred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and title of certifier ACILLIA Chd	ma	29c. Licens	number	290	2 19 09	th, Day, Year)
Y	√		30. Name and address of person who completed cause of death (Item 2	a) (Type, I	Print) Ar	may	oles m	10 21	461
	Sta Registr		31. Date filed (Month, Day) Year) 32 Registrar's Signature FEB 2 0 2009	pa	arel	P			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 05248 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year LILLIAN E. VUKOV FEBRUARY 13, 2009 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7959 TELEGRAPH RD LOT 84 SEVERN ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 □ F Yrs. Director 217.52.4774 62 NOV 20, 1946 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 □ No ANNE ARUNDEL **SEVERN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7959 TELEGRAPH RD LOT 84 items 23a 21144 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 □Yes 2XX No Specify þ Specify: 3 □ widowed 4 □ Divorced "natural", WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAB DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOC WILSON ೭ VIRGINIA FITZPATRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JORENE SLOCUM 7959 TELEGRAPH RD. LOT 84 SEVERN, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY, INC 2.19.2009 BROOKLYN, MD of Funeral Service Licenses FINK FUNERAL HOME, P.A. GRECORY FIN 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death Enter the dive se, or co olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Juse (Fin N **Physician** disease or condition resulting in death) 91 /Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician s the burlal Physician/Medical as nse s IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) o 1 Yes 2 DNe been signed by the should be detached 9 Unknown σ, Part II. Other significant conditions contributing to death but not poulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Ulmonau Itru etime 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy certificate Division of Vital 1 ☐ Yes 2 N Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Ho Other: 4 Nursing Home 5 2 Sesidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28h Time of After 28d. Describe how injury occurred or Attending 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital within 24 hours 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gorbaly mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February17 ,2009 Linda Weidner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6919 German Hill Road Baltimore Dundalk | Tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day) | Hours | Min. | Sept 13, 1956 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ XF 52 Maryland 220-82-3373 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, It - Medical Examinar Intest by notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Funeral Director Md. Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 6919 German Hill Road 21222-1154 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Office Assistant State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Kahler Edward Ziolkowski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a George L. Weidner(Husband) 6919 German Hill Road Baltimore, Md. Department of Health Important: If item 27 any injury or other trong once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 2-20-2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service/Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jastwesophog year Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as a consequence of Due to (or as a consequence of) physician a s the burial-t Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D07930 February 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 Marvin J. Feldman, M.D. 227 St. Paul Place 4th Floor Baltimore. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

FER 9 0 2000

DHMH 17 Rev 1/2001

VOID

CERTIFICATE

2009-05250

SEE

CERTIFICATE #

2009-05853 4/21/09dlh

Amend #26, per MD 8888 2/20/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** HERBERT P. WARREN. JR. 01:45 AM 72009 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Square Hospital osedale If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months **¼** M 2 □ F 7/28/1932 Director 218-28-8028 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expandent mass by restined at 1 ☐ Yes 2X No Director BALTIMORE COUNTY MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8820 WALTHER BLVD. APT. 4327 21234 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NEVER EMPLOYED N/A 12TH GRADE and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I HERBERT P. WARREN, SR. TERESA C. MCNEILL ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau ROBERT J. WARREN/BROTHER 8810 WALTHER BLVD. APT. 2225 PARKVILLE, MD 21234 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEM. 2/20/2009 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Yeath Nac 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adrenal insufficiency, Addison's disease /Medical Due to (or as a consequence of): Examiner fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Aspiration

Due to (or as a consequence of): burial-tran P.O. Box 68760, attending physician for use as the buria Physician/Medical as If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause 5/4en in Part I. Division of Vital Records, <u>۾</u> fracture-Left, Congestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an valve has performe 1 ☐ Yes 2 ☑ No 1 □Yes 2 No colon concer Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home -5 Thouside 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Qay, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation fell acts of Conch 281. Location (Street and Number or Rural Route Number, City or Town, State) Walther Bluck t Conch 1 ☐ Yes 2 ☑ No 5/10/2001 2- Accident 6 □Could not be 3 ☐ Suicide 28e. Place of I, jury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 123 U 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANKLIN DR Karen Gira Square DR Balto 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Mary		rtment of H			giene Reg. No.2 (009	05252
H	Physici	on	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		Year	3. Time of Death
	/Medic		Shirley A. W					Month	17	2009	225 PM
	Examin	ner	4a. Facility Name (If not institution, give ST AGNES HC	SPITAL		4b. City, Town, or BACT I	MORE		4c. Cour	nty of Death N/A	
	Funeral		Social Security Number 6. Se	_ , - , - , -	n yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birt	h v, Year)		ace (State or Foreign
	Director		214-50-6653 1L Usual Residence of Decedent	JW ZEAT	65 Yrs.			9/4/4	4	MD	
	ıryland show	Ļ	10a. State 10b. County MD N/A	10	Baltimo					10	0d. Inside City Limits
	the Ma 28a-f s	ecto	10e. Street and Number		Daiting	10f. Zip Code			10- 0"		My Yes 2 No
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Everning rulet be notified at	Funeral Director	313 Yale St.			21229			10g. Citizen o USA		uy?
	tems tems	uner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. R	ace - America lack, White, e	
320	irs afte	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		□Yes 2 XNo	Specify:		Spec	AIrı	.can
5-0036	72 hou nature dical E	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		ent's Usual Occupa		orkina	16b. Kind of	Business/Ind	
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_	~ = 0 2	Be	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	000).t	18. Mother's Na	ıme (First, Middle,	Maiden Surna	ame)	
ya	2 should be and Mental is marked or raumatic ever	5	Edward Talor					Taylor			
Ma	id 2 sh ith and 27 is m traum		19a. Informant's Name/Relationship (Ty Shirley R. Wall		19b. Mailing	g Address <i>(Street a</i>	and NumberorF 7 AV⊖ - F	Rural Route Numbe	r, City or Tow	n, State, Zip	Code)
e,	of Hea item ?		20a. Method of Disposition	2	20b. Place of Dispos		a)	Date	20c. Location		vn, State
altimor	Page Iment tant: If jury or		Note: 1	emoval from State	Mt. Car	mel Cem	$\frac{1}{1}$ 2/2	1	Balt.	•	
Dall	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens	ee	5 1	Name and Addres	is of Facilitar ir Rd,	i P. Cl Balt.,M	ose F D 212	.Svs,	PA 05
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the ne cause on each line.						.1	Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	CELEBRI		SCULA	R AC	CIDENT	_		Onset and Death
	Examiner			Due to (or as a co	nsequence of):						V
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	risequence of):						
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	 Due to (or as a co	insequence of):						
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20	ertifica ling ph e as th	Medi	IF FEMALE:								
ox .	w requires that the deam certificate be executed to be executed to be signed by the attending physician and should be detached for use as the burial-transit	sician/Medical	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3 🗌	Ectopic pregnancy			- 1	ate of deliver	y Day Year
j]	by the	Physic	1 ☐ Yes 2 V☐ No 9 ☐ Unknown	9 Unknown	e or death 5	Other (specify)					,
'n.	es ma igned be det	by P	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the un-	derlying cause give	n in Part I.				cause of death?
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je j	s certificate has t lirector, page 2 s	Completed				18.		24a. Was a autops perfor	sy L		sy findings available inpletion of cause of
N Ear	antificat	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only or		1 ☐ Yes	2√2 No
5	this ce	၉	I les 2 19140		2 ER/Outpatient		4 LI Nursing	Home 5 ☐ Reside	ence 6 □O	ther (Specify,)
5	th. t After t funer	tion	27. Manner of Death Valural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye.	ar) 28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? ′es 2 ∐ No	28d. Describe h	ow injury occu	ırred	
N .	er dea	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre			28f. Location (S. City or Town	reet and Nun	ber or Rural	Route Number,
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	on the nospital of Attending Priysician: The law requires that the death certification to the notice state of the the state of the Funeral Director. After this certificate has been signed by the attending placempletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the state of the completely filled in the funeral director.	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examination	sician: To the best of maner: On the basis of exa and manner stated.	y Knowledge, death amination and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occ	e, and due to the curred at the time, o	ause(s) and rate and place	manner as sta e, and due to	ated. the cause(s)
1	withir comp	Me	29b. Signature and title of certifier			29c. License			9d. Date sign	ed (Month, D	lay, Year)
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57			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P	rint)	E RO	HTIMAR		1177	9
	Sta		31. Date filed (Month, Day, Year)	32 Penistrar's 9	Signature	orlint) AV AV	- 07	0.1110			1
D	Registra	ar	FEB 2 0 20	US /- Process	1 1. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Leo A. Wittstadt e6 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ITATION CENTER 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-13-1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days Hours 1**X** M 2□ F 219-22-1110 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2X No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 1016 E Wheel Rd Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Architect Architectual Firm Ith and Mental Hygiel 27 Is marked other the r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Andrew Wittstadt Mamie Fischer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If Item 27 Is Bel Air, MD 21015 Dorothy Wittstadt 1016 E Wheel Rd (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. Dulaney Valley 02-21-2009 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause if each ling. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of leath
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) nd manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) and add tem 23a) (Type, Print) drives

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

FFR 2 0 2009

32.

Registrar's Signature

Parks

VOID

CERTIFICATE

2009 - 05254

SEE

CERTIFICATE #

2008 - 43750

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in Black State of Maryland / D	Indelible Ink. Ensure All epartment of Health and M	Iontal Hya	iono	05055
			Certificate of Death	Re	g. No. 2009	05255
Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month	n Day Year	3. Time of Death
/Medica	al -	LUTHER WASHINGTON JR.		2/16/2		8:25 a M
Examine	r	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral	٩	Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Clinton day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Prince Ge	nplace (State or Foreign
Director		251-40-3042 1₺ M 2□ F 80 Y	rs. Months Days Hours Min.	7/31/19	28 Edg	efield, SC
and w	- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Maryik f sho	.					1X∑Yes 2 □ No
r 28a		Maryland Prince George's Foresty 10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cou	untry?
th with		7702 Bethany Drive	20747	U	nited Stat	es
r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
s afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Bla	ck
2 hour	ted	15 Decedent's Education 16a. [Decedent's Usual Occupation		16b. Kind of Business/I	ndustry
thin 7; e. an "n	Completed	(Specify only highest grade completed) (Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)	ing		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, sther than "natural", or items 23a or 28a-f show ant, It. Medical Exactions in the could be a served and the could be a served and the could be a served and the could be a served as a served and a served a served and a se	် ပ		ectrician	(Final 84) July 8	Private	
he fill he fill he dot	Ď	17. Father's Name (First, Middle, Last) Luther Washington Sr.	18. Mother's Name	a Frasie		
should nd Me mark markimatic	2		Mailing Address (Street and Number or Rur			ip Code)
nd 2 salth al			02 Bethany Drive For			
of He of He r othe		20a. Method of Disposition 20b. Place of I			20c. Location - City or 1	
Page ment ant: II ury o		1 LABurial 2 Li Cremation 3 Li Removal from State	memorial 2/23	/2009 S	uitland, M	aryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 with the Marylan Beatment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Wedical Examination of the product of the pr		21. Signature of Funeral Service Licenses	22. Name and Address of Facility ope	Funeral	Homes, P.	A.
70 = 40		23a. Part 1. Enter the disease, of complications that caused the death. Do no	5538 Marlboro Pike			and 20747 Approximate
		shock, or heart failure. List only one cause on each line.	or enter the mode of dying, such as cardiac	or respiratory arre	751,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of	me			
Examiner)	,,			
₽/ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying):			
e executed	Examiner	Cause (Disease or Injury that initiated events c).			
burial	_	Due to (or as a consequence of).			
Attending Physician: The law requires that the death certificate be reach: sector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	d				
th cert	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deli	*
e dear	Sicie	1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year
hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the significant conditions.	the underlying cause given in Part I	23e Did tob	acco use contribute to	the cause of death?
e law requires that the di has been signed by the ie 2 should be detached	g S	Severe COPD.	No arrabilying dadde given in rate.			obably 4 Unknown
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The laste has	dmo	- NOTE BIOTIE	ACALLO	autops: perforn	y prior to o ned? death?	ompletion of cause of
lan: rtiffica ctor, p	a l	25. Was case referred to medical	26. Place of Deat			2 🙀 No
hysic his ce	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	oatient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Reside	nce 6 □Other (Spec	cify)
ling P	:i	Tending	ury Work?	28d. Describe ho	w injury occurred	
death death ctor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr	M 1 Yes 2 No	28f Location (St	reet and Number or Ru	ml Poute Number
after after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	in street, lastery, office	City or Town		rai i loate i valinoci,
	Medical C	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, 2 ★ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within To the comp	§ ₽	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month	ı, Day, Year)
		1 Dayusatu	D 0047553		2-18.09	7
5	1	30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)			
	1	31 Date filed (Month Day Year) 32 Begistrate Signature	d Clinton, Maryland	20735		
Stat Registra		FEB 2 0 2009 Lisur D.	backer			
HMH 17 Rev 1/20		Jan Jan			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death sillorne Month **Physician** 15P M Mary · 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Christ 6. Sex If Unde If Under 24 Hrs 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number 8. Date of Birth **Funeral** Months Days Hours Min. 1 M 20 F 218-36-7343 Yrs. Director 8.2.1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No Saltimore WD 10e. Street and Number 10g. Citizen of What Country? ö Reverd 23a タルタルク Funeral 14. Race - American Indian, Black, White, etc. or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Black natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item In Elementary/Secondary (0-12) College (1-4or 5+) Dresser usmet 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Thelma ပ Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilborne heverdy Baltimore, MD 212
ate 20c. Location - City or Town, State 1 ictor 030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vougna C. Greene Funeral Services any In once, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. 4905 York B Baltimure, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 14 No Vital 1 □Yes Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Hospice ō this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death, To the Funeral Director; 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 cause of death (Item 23a) (Type, Print)

'Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

FEB 2 0 2000

Darks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			for State Registrar		ar y rain	-	rtificate of l			Reg. No. 200	19 05251	
	Dhysisi		1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea Month		3. Time of Death	
	Physicia /Medic		Albert Eug		ner				Februar	cy 14 20	09 4:35 A ^M	
	Examin	er	4a. Facility Name (If not institution, giv Carroll Hospice					Location of Death	1	4c. County of	Death Carroll	
	Funeral	-	5. Social Security Number 6. S	Sex 7. Age		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9	9. Birthplace (State or Foreign	
	Director		214-32-4426	1 X M 2□ F	76	Yrs.	Months Days	Hours Min.	June 17		Maryland	
	and ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	
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	or 28% e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha		
	ath wi	rall	12801 Bunker H			1		21791		U.S		
	ter de items iner n	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent E Armed Forces? 1 XYes 2 □ N		5. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.	
036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show Usal Evaniner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1∐Yes 2⊠No	Specify:		Specify:	White	
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d 2	e filed withir al Hygiene. I other than vent, the M	BeC	17. Father's Name (First, Middle, Last))						Maiden Surname)		
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Jar	de la maria		19a. Informant's Name/Relationship (er, City or Town, St		
e,	is 1 and 2 of Health a item 27 Is other trai		Jon D. Wisner/ so 20a. Method of Disposition	n	20b. Pl		Blue Moun sition (Name of natory or other place		Date	mont, MD		
Baltimore, Maryland	Pages nent of hant of hant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				natory or other place 1 Mem. Ga:		7/2009	Frederic	~k MD	
alti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer		1					neral Ho		
8	99 E 8 9		(attaine)	1.7/ac/26			04 S. Mai			oro, MD 2		
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	ence of):						
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68	rtificat ng phy as the	Medical		, u.								
Вох	eath cer attendir for use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗀 Fetal	death 3	Ectopic pregnancy	/		23d. Date of		
0.	he deg	Physician/I	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5	Other (specify) _			North	, bay rear	
٠ <u>.</u>	Physician: The law requires that the death ce this certificate has been signed by the attendi ral director, page 2 should be detached for use	by Ph	Part II. Other significant conditions	ontributing to death bu	ıt not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?	
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sior	Attending r death. sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	, rear	падагу		Yes 2 □ No				
Division	or Att	Certification:	3 Suicide 6 Could not be determined		iry - At ho :. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (S City or Town	Street and Number n, State)	or Rural Route Number,	
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	he Ho in 24 h he Fui pletely	Medical	(Check only one) 2 Medical Exar	miner: On the basis of and manner sta	examinat	tion and/or in	vestigation, in my o	pinion, death occu	irred at the time, o	date and place, and	d due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	K. To	r N	11	29c. License	e number	2	29d. Date signed (Month, Day, Year)	
				June	1-	200	Doi: 10 >	1 518		12-16	5-0)	
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	Sta	te	31. Date filed (Month, Day, Vear) —	32. Registion	ar's Signat	ure	1		الكالك	1111	,	

Registrar

			For State Registrar	State of Ma		oartment of F e <i>rtificate of</i> I			Reg. No. 20	09	05258
	Physicia	m	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		ALICE	P	WEA		L d (D)	Februar		009	5:05 A M
,	Examin	er	4a. Facility Name (If not institution, give st Frederick Memori		t o l	4b. City, Iown, o	r Location of Death		4c. County		-
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	h rred	ericl 9. Birthp	ace (State or Foreign
	Director		026-20-8674	м 2 Д F	91 Yrs.	Months Days	Hours Min.	October 2	26, 1917	Couin Mass	achusetts
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				110	od. Inside City Limits
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	ems er mu	Funeral	11. Marital Status	2. Was Decedent E	ver in U.S.	3. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blac	e - Americ k, White, e	
30	be filed within 72 hours after death with the Maryland rial Hygiene. did Hygiene. do other than "natural", or items 23a or 28a-f show event, I're Medical Eraminer must be retified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	0	1 □Yes 2 No	Specify:		Specify		
3-003p	hour		15. Decedent's Educa	ation	16a. De	cedent's Usual Occup	ation	1	16b. Kind of Bu		
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7	ed with	Con		4	<u> </u>	Homemaker			0wn		
and	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•		e)	
2	2 should be and Mental is marked aumatic ev	ှ	Halbert E. Pierc		10h M	iling Address (Street		Plympto		State Zin	Codol
Z			19a. Informant's Name/Relationship (Type Charles L. Weaver			76 SE Cora					
ā,	is 1 and of Health item 27 other t		20a. Method of Disposition	, 01.7001		position (Name of rematory or other place	,	Date	20c. Location -		
Ē	8 2 = 5		1 ☐ Burial 2 🛛 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Crematorium	אטונטוא	ry 17, 09	Bethes	da, N	Maryland
pair	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License		M01546	22. Name and Addre Robert A. Po 7557 Wiscons	ss of Facility Imphrey Fund	eral Home	/Bethesda-	Chevy	Chase, Inc.
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to	the death. Do not					1110 2	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	cause on each line		lo carditi	^				Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence of):	ocerditi	1.		0 +		1
	Examiner	_	Sequentially list conditions, b.	DEPOSITANT AND ADDRESS OF	Ac	ute Mi	ocer die	4 In	toche	2	days.
_	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ui as a	consequence of).		J				
_	execu n and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	,					
58/50,	rtificate be executed ng physician and as the burial-transit	edical	d.								
9	ntifica ng ph		IF FEMALE:							7.5	
Š D	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome o 1 ☐ Live birth 2	2 ☐ Fetal death	3 ☐ Ectopic pregnanc	y		23d. Dat	e of delive	ry Day Year
- -	he de the a	ysic	1 ☐Yes 2 ☐₩6 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify) _					, , , , , , , , , , , , , , , , , , ,
J.	that the	P	Part II. Other significant conditions cont	ributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contr	ibute to th	e cause of death?
cords,	quires n sigr ald be	d by	CMF, De	mentia	Sp	nal Ste	2'120n	1 🗆 Y	′es 2 □ No	3 ☐ Prob	ably 4 toknown
000	aw rec	Completed			1 -1			24a. Was a		Vere autor	osy findings available
ř	The Ist	mo						autop perfor 1 □ Yes	rmed?	rior to cor leath? □Yes	npletion of cause of 2 □No
vital	ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat				
<u>-</u>	hysic this co	၉	1 Yes 2 No		nt 2 ER/Outpa		4 L.I Nursing Ho		dence 6 □Oth)
DIVISION OF	ding F	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day,	y 28b. Time (<i>Year)</i> Injur	y Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occurre	ed	
<u>s</u>	Attenc death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ry - At home, farm.		Yes 2 110	28f. Location (S	Street and Number	er or Rura	I Route Number.
2	al or A safter I Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier 1 ☐ Certifying Phys (Check only one)		examination and/o						
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
			M. Korzon,	MD		D66	5166		2 1	3 0	7
)			30. Name and address of person who cor	-			_				
<i>'</i>	Sta	to.	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	7th Street	t, Freder	ick, Mai	ryland 2	1701	
	Sta Registr		FEB 2 0 2009	Brance	A. 100	alled					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND, TTEM#1 perPHYS, G889, 3/4/09 WS
State of Maryland Department of Health and Mental Hygiene

			1 - State Registrar			Ce	ertificate of	Death		Reg. No.	2009	05259
	Physicia	an	1. Decedent's Na	me (First, Middle, Last	Bettie A	nn Umstea	d Witt		2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		BETTIE	ANN UNST		•			FEBRUAL		, 2009	3:46 A M
	Examin	er		(If not institution, give	•		4b. City, Town, o	r Location of Death			County of Death	
-				N MARYLAND Number 6. Se		(la la at hinth day	CLINTO	If Under 24 Hrs.	8. Date of Bir		RINCE G	
	Funeral Director		5. Social Security 220-40- Usual Residence	3957	™ 2 X 1 F 7. Age	(In yrs. last birthday Yrs.	Months Days	Hours Min.	APRIL	ay, Year)	Coui	place (State or Foreign ntry)
	land ow		10a. State	10b. County		10c. City, Town or I	ocation				1	0d. Inside City Limits
	Many F-f sh	ţ	MD	PRINCE G	EORGE'S	DISTRI	T HEIGHTS	5				1 X Yes 2 □ No
	h the	Director	10e. Street and N	umber			10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	th wit		2012 TI	BER DRIVE			20747	7		US.	A	
	ems	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H	lispanic Origin? (Span. Mexican, Puerto	pecify Yes or No	D- 14	4. Race - Americ Black, White,	
21215-0036	within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Madical Examination radiostat	by		rried 2 X Married 4 □ Divorced	1 □Yes 2 🕅 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🗓 No				Specify:	ITE
<u> </u>	"natu	lete	(Sp	 Decedent's Edu ecify only highest grad 	ication le completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retire	pation during most of worl	king	16b. Kind	d of Business/In	dustry
12	within iene. than "	Completed	Elementary/Sec	condary (0-12)	College (1-4or 5- YRS	F)	GO PLANNEF			IINT	TED AIR	TNFC
	Hyg the	e Cc	17. Father's Name	(First, Middle, Last)	IKS	CARC	O LLANNER	18. Mother's Nam	ne (First, Middle			PINES
Maryland	o g to	To B	GORDAN	J. UMSTEAD				ELTZA	BETH LI	SKEY		
ary	shou nd M mar	-		Name/Relationship (T	ype. Print)	19b. Ma	ling Address (Street			-	Town, State, Zip	o Code)
	12 mg		L. EDWA	RD WITT /	HUSBAND	201	L2 TIBER I	DRIVE DI	STRICT :	HEIGH	TS, MD	20747
Jre,	ss 1 a of He Item		20a. Method of D	isposition		20b. Place of Dist		i	Date		ation - City or To	own, State
Baltimore,	permit. Pages Department of I Important: If Its any injury or o			Cremation 3 ☐ 1 5 ☐ Other (Specify)			CEMETERY		21-2009	ROC	KVILLE,	MD
alt	permit. Departr Importa any inj		21. Signature of	ne service Lions	see		22. Name and Addre	ess of Facility MA	RSHALL T	S FUN	ERAL HO	ME OF MD
_	90 F # 9			11117	DONALD 1	R. GRAY	4308 SUIT	LAND ROA	D SUI	TLAND	, MD 2	0746
N. Carlot	Physician /Medical	ê y	23a. Part 1/ Enter shock or he Immediate Caus disease or condi- resulting in death	tion	ne cause on each lin a.	OMON	nter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,	20	Approximate Interval Between Onset and Death
7	Examiner		Trouming in count		Due to (or as a	a consequence of):						
	383	-	Sequentially list of any leading to cause. Enter Und	onditions,	b. Due to for as a	consequence of						
	od d ansit	Examiner	cause. Enter Und Cause (Disease of that initiated ever	derlying or injury								
o,	icate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):						
68760,	ate be nysici ne bu	ical			d							•
39 x	certificate be executed Iding physician and Ise as the burial-transit	Medical	IF FEMALE:									
0. Bo	death e atter d for u	Physician/l	23b. Was decede in the past 1 1 Tes 2 9 Unknow	2 months? ☑No	23c. If yes, outcome of the control	2 ∐ Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23	3d. Date of deliv Month	ery Day Year
ď.	s that ned b	by Pt	Part II. Other sign	nificant conditions co	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
rds	v require been sig should b	q pa							1 🗆	Yes 2	No 3□ Pro	bably 4 ☐ Unknown
Division of Vital Records,	e 2	Completed								psy ormed?	prior to co death?	opsy findings available impletion of cause of
ital		ø	25. Was case ref	erred to medical				26. Place of Dea	1 □Yes		1 □ Yes	2 ∐ No
}	Physician; r this certific ral director,	To B	examiner? 1 ☐ Yes 2	No	Hospital:	nt 2 🗆 ER/Outpati	ent 3 DOA Oth	or'			☐ Other (Speci	fy)
n 0	ding Physician: h. After this certific funeral director,	L:uc	27. Manner of De 1 Matural	ath 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju		28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
sio	Attending ir death. ector: After by the funer	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	Vacant com			Yes 2□No				
Ξ	or At ifter d Direct in by	Certification:	4 Homicide		28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
ш	pital		29a. Certifier	195 Continue Div	reinian. To the host o	of must be accorded as a do-	0 th		and don to the	(-)		etate d
	To the Hospital or Attent within 24 hours after deatt To the Funeral Director; completely filled in by the	Medical	(Check only one)	2☐ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occu	rred at the time	, date and	place, and due t	o the cause(s)
	Vait To 1	2	29b. Signature ar	title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			7/6				_ リー	10277		CB.	18,	LUCT
1	V 9		r. Wis	dress of person who c	(A-1). 1	2070 6	LA LINE	CENTA	2 W+	441	UF, MA	d, 2060
	Sta Registr		31. Date filed (Mo	FER 2 0 2	32. Registra	r's Signature	parkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05260 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 2009 10:15 AM February Katherine Brnko Ashford /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hillwood Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F Days Jun 20, Illinois 319-16-1563 38 1920 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location Funeral Director 1. Yes 2 □ No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4417 Walsh Street 20815 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 No Completed by If Yes, Give Year or Dates: Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Suzana Jurisa Jan Brnko ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 Walsh Street Chevy Chase, MD 20815 Richard K. Ashford/son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Arundel Crematory 02/05/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signatur of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic Obstructive Pulmonary Disease years disease or condition resulting in death) Due to (or as a consequence of) Alzheimer's Dementia vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Anemia years Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☒No Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ZOther (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the cause(s) and manner as stated. Medical (Check only

Funeral

Director

ral", or items 23a or 28a-f show Examiner mult be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

traumatic event, the Madical

Department of Health a Important: If Item 27 is any injury or other tra

Physician

/Medical

Examiner

and burial-tran

attending pl

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detached

page 2 should

funeral director,

filled in by

s after dea... ral Director: Aft

24 hours a

To the Hosp within 24 hor To the Fune completely fi

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

Dave Chen.

29c. License number D64059

Fernwood Road Suite 100 Bethesda, MD 20817

29d. Date signed (Month, Day, Year)

February 3, 2009

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 10215

th, Day, Year)
FEB 0 6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death [□]7, 2009 **Physician** February Dorothy Preston Adams 12:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkton er 1 Year | If Under 24 Hrs. Union Hospital of Cecil County Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 213-16-4069 1 □ M 2 👿 F 86 Director April 19,1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic executions. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Ceci1 North East 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 71 Falls Road 21901 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Completed by Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Preston Mary Potts 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Adams / Son 71 Falls Road, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State ¥¥Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12, 2009 Elkton, Maryland 21. Signature of Funderal Service Licens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sie aruchi nond Haeine roll Minour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner xperter. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the burial-tran and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1□ Yes 2 No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl o Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D04B23 Tru cerl Hs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West CHIH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 9 2009

DHMH 17 Rev 1/2001

09-01334
Annette Abbott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State	•	ate of Death		Reg	_{3. No.} 200	19 052
Physicia dical Examir	n/	Decedent's Name (First, Middle,Last)				2. Date of Death Month February 1		3. Time of Death 2212 hrs
oicai Examir €		Annette L. 4a. Facility Name (if not institution, give street and number)		Abbott	r Location of Death	February 1	4, 2009 4c. County of Deat	
		Peninsula Regional Medical Center		Salisbury	Location of Death		Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F	e (In yrs. last birth 42	nday) If Under 1 Ye Months Da		8. Date of Birth	Co	rthplace (State or Forei ountry) Texas
ny	F	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limit
ne Maryland or 28a-f show any fied at once.		MD Wicomico						1 Yes 2 X N
arylan 8a-f sl	Director	10e. Street and Number	Hebr	10f. Zip Code		10	g. Citizen of What Cou	intry?
the M a or 2 tiffed		6611 Quercus Drive		21	830		USA	
imore, MD 21215-04)36 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent		13. Was Decedent of H	ispanic Origin? (Sp			rican Indian, Black,
or deat	핊	1 Yes 2	X No			r tiouri, oto.,	Specify: Whi	to
irs afte	<u>a</u>	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company)	npleted) 16a, [1 Yes 2 X N		ork done	16b. Kind of Business	
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 8		during most of working lif	e. DO NOT use retir	red)		1
vithin ere.	립	10		Salesperso			Retail	
Bartimore, MD 21215-005; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		17. Father's Name (First, Middle, Last)		_	18.Mother's Name		,	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To Be	George F. 19a. Informant's Name/Relationship (Type, Print)		e, Jr. . Mailing Address (Stre	Marion C			ichols e. Zip Code)
MD and 2 shot alth and 27 is raumatic	-1	Marion C. Goslee - Mother	4	718 Oakridg			·-	
e, l l and Healt l'item		20a. Method of Disposition	20b. Place o	f Disposition (Name of cory or other place)		Date	20c. Location - City o	r Town, State
Bartimore, permit. Pages lar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	aic	Cemetery	2_	19-2009	Hebron, N	Marvland
anti rmit. spartur nports jury o	İ	21. Signatur Funeral Service Licensee	/	22. Name and Addres			neral Home	iai y iaiia
	4	23a. Part I. Enter the disease, or complications that caused	<i>9</i> .				bury, Mary	land 21804 Approximate Inter
Physician /Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. COronary	artery		g, such as cardiac o	respiratory arre	St, SHOCK, OF HEAR	Between Onset a Death
	-	h hyportone		eroscleroti	c cardiov	ascular	disease	
	Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		CIOOCICIOCI	<u>c cararo</u> ,	abcarar	arbeabe	
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cuted nd transit		d.						
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Box 68760, e death certificate be the attending physic ed for use as the burned for the burner and the burner a	sician/	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown	ne of pregnancy 2 time of death 5		Ectopic pregna	ncy	23d. Date of delive Month	ry Day Year
Vital Records, P.O. B. ysician: The law requires that the de his certificate has been signed by the director, page 2 should be detached if	Phy	Part II. Other significant conditions contributing to death	h but not resulting	in the underlying cause	given in Part I.		pacco use contribute to	
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an:]	a l	25. Was case referred to medical examiner?		26.Pla	ce of Death (Check	only one)		
	을 일	1 Yes 2 No	ent 2 🗸 ER/01				Residence 6 Othe	er:
Nita		27. Manner of Death 28a. Date of Inju (Month, Day,Y	ear) 28b.		ury at Work? Yes 2 No	28d. Describe h	ow injury occurred	
n of Vita ding Physicia After this ce	<u></u>		- 1			28f Location (S	treet and Number or R	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician; To the best of mone) 2 Medical Examiner: On the basis of examiner.	y knowledge, dea	ath occurred at the time, nvestigation, in my opinio	date and place, and on, death occurred a nse number	or Town, St	ate) e(s) and manner as stand place, and due to t	nted. he cause(s)
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Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director. After this ce completely filled in by the funeral direct	Medical	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician; To the best of mone) 2 Medical Examiner: On the basis of examiner and francer stated.	y knowledge, dea mination and/or ir	ath occurred at the time, nvestigation, in my opinion 29c. Licer	date and place, and on, death occurred anse number	or Town, St	ate) e(s) and manner as stand place, and due to t	nted. he cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Lee Aaron Month Vear 6:30 AM 01 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sqlis bury /VI If Under 1 Year Wunder 24 Hrs Days Hours Min. Hospice Wicomico casta Lake 8. Date of Birth (Month, Day, Year) 07/19/1927 curity Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F 236-34-9871 Director 81 West Virginia Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits artment of Health and Mental Hyclene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, t<u>he Medical Examir or must to notified at</u> Director 1 ☐ Yes 2 ☐ No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 1605 Piney Grove Ct. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify white 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hydene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Marcella Eschstruth Robert Blaine Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5761 Royal Mile Blvd., Salisbury, MD 21804 Pages 1 and 2 s' ment of Health ar Linda Hooker/daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Trinity Episcopal Church Cemetery permit. Pages Department o Important: If i any injury or once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/09 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signature of Funeral Service License 2HOT10Way Pufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** ANCREATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIABETE Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2₽No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 TNo 1 ☐ Yes 2 No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICIZ 1 | Yes 2 | 2 | 1√10 Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2

Registrar

(Check only

29b. Signature and title of certifier

WARRY

29d. Date signed (Month, Day, Year)

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2009

05264

Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	For State Registrar			Olule of	iviai yiai i			rificate of			nomai i i	Reg. N	- C	105	J U	0204
	1. Decedent's Nam	ne (First, Midd	lle, Last)								2. Date of De)ay	Year	3. Time	e of Death
ı	VIRGINI	A LEOT	'A AN	DERSON							Febru			200	7 10	:10 AM
	4a. Facility Name ((If not institution	on, give st	reet and numb	0			4b. City, Town, o	r Locatio	n of Death	1	4	c. County	y of Dea	th	
	WMHS		6. Sex		AM			Cum/	DEIN/	ANC er 24 Hrs.	8. Date of Bi	rth	H		ga N	te or Foreign
	5. Social Security N 215-20-6 Usual Residence of	5063		M 22 F	82		rs.	Months Days	Hours		01-27-	ay, Yea		C	NSYLV	
ŀ	10a. State	10b. County	у		10c. City	y, Town	or Loca	ation							10d. Inside	e City Limits
3	MD	ALLEG	SANY		FRO	OSTE	BURG								1 🔀 Y	res 2□No
undial Dilecto	10e. Street and Nu	umber		11.01				10f. Zip Code				10g. (Citizen of	What Co	ountry?	
3	5 MAPLE	E DRIVE	2					21532				U	.S.A.	•		
	11. Marital Status			2. Was Deced Armed Force	ent Ever in U.: es?	S.	13. W	as Decedent of H Yes, specify Cub	lispanic (an, Mexic	Origin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - Am	erican Indiar te. etc.	١,
2	1 ☐ Never Mar 3 ☑ Widowed			1 □Yes 2 If Yes, Give Year or Dat	X No			□Yes 2XNo	Speci				Specii		WHITE	
nandillo	(Spe	15. Decede	nt's Educa	ation completed)		16a.	Decede	ent's Usual Occup ind of work done	ation durina m	ost of work	ina	16b.	Kind of B	Business	/Industry	
1	Elementary/Sec		J	College (1-4	or 5+)	CI	life. Do	O NOT use retire	d)		Ü		EWIN	C		
3	11 17. Father's Name	/Eirot Middle	(act)			31	LAMS	STRESS	18 Mo	thar's Nam	e (First, Middle					
2	GEORGE 1										WINTER					
	19a. Informant's N	Name/Relation	ship (Typ	e. Print)		19b.	Mailing	Address (Street	and Nun	nber or Rui	ral Route Numi				Zip Code)	
31.	GEORGE	KROLL	Ŋ	NEGHEM_				LUZNAR	LANE				2153			
	20a. Method of Dis	•	3 □ Re	moval from St		lace of emeter	Disposi y, crema	ition (Name of atory or other pla	ce)		Date	20c.	Location	- City or	Town, State	9
	4 ☐ Donation					TLA		IEM GARD			-2009	CUM	BERL	AND,	MD	
	21. Signature of F	321			moss	47		Name and Address		SOW	ERS FUN		L HO -215	ME,	P.A.	
	23a. Part 1. Enter	the disease, o	or complic	ations that car	used the death	n. Do r	ot ente	r the mode of dyi	ng, such	as cardiac	or respiratory	arrest,	-610	34		Between
	Immediate Cause disease or conditi	(Final			Din	9	N	ONI	7						Onset a	ind Death
1	resulting in death))	C a.	Due to (o	r as a consequ	uence c	of):								2	+ word
	Sequentially list co	onditions,	b.;													
Lyaillite	cause. Enter Und Cause (Disease o	lerlying -	2	Due to (o	r as a conse i	Jence c	of):									
7	that initiated event resulting in death)	ts	c.	Due to (o	r as a consequ	uence c	of):									
Calical			u.													
	IF FEMALE: 23b. Was deceder	nt pregnant	23	c. If yes, outco	ome of pregna		۵□	Ectopic pregnance						ate of de		
ny sicial in	in the past 12 1 ☐ Yes 🛣	No			int at time of d			Other (specify) _	- у				М	lonth	Day	Year
	9 Unknow										OD- Did	4=b===		atuila uto d	to the sauce	of dooth?
	Part II. Other sign	iificant condit	ions cont	ributing to dea	ith but not rest	uiting in	the und	deriying cause giv	en in Pa	rt I.			2 □ No		to the cause	Unknown
	-												1			
completed by											24a. Wa:	s an opsy formed?		. Were a prior to death?	completion	ngs available of cause of
	-		. 1								1 □ Yes	2 🖼		1 ☐ Ye		
3	25. Was case refe examiner? 1 Yes 2		<u> </u>	ospital:		FD/2	Am mat	o□ po. Tott	ner:		th (Check only		6 🗆 🗆	tha- 12		
2	27. Manner of Dea	_		28a. Date of		28b. T	ime of	3 DOA 28c. Inju		Nursing H	ome 5 Res 28d. Describe			<u>`</u>	есну)	
[]	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendi inves	ing tigation	(Month	, Day, Year)	li	njury		rk?]Yes 2	□No						
1	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	not be mined	28e. Place o	of Injury - At ho g, etc. <i>(Specif</i>	me, fai	m, stre	et, factory, office			28f. Location City or To	(Street	and Num	ber or F	Rural Route I	Number,
	4 LI Monneide			buildini	, etc. (Specif	,,					Oily of 10	, 1111, Oli				
Medical Cel Illication.	29a. Certifier (Check only one)				sis of examina			occurred at the t estigation, in my								se(s)
ME	29b. Signature and	d title of certifi	er	11	7/			29c. Licen	se numbe	er		29d. l	Date sign	ed (Mor	ith, Day, Yea	ar)
) (101				T	23	337	/	1	FEB	15	, 200	09.
	30 Name and add	dress of perso	n who cor	npleted cause	of death (Iten	n 23a) (Type, P	Print)	7		1.	. /	. /	i	,200 d, N	2 /
	31. Date filed (Mo	R LF	mr	AN, M	D 4 gistrar's Signa	04	5	eton	Dr	ive,	Cur	n D	er/	AN	a,11	100
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State

Registrar

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		_	1 _ State		partment of H <i>ertificate of L</i>			giene 1. 2009	05265
			Registrar 1. Decedent's Name (First, Middle, Last)		Crimoato or E	704.77	2. Date of Dea	th	3. Time of Death
	Physicia /Medic		Clyde Randall Asbury	7			Month Februar	y 10, 2009	1228 M
· P	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
_			Union Hospital 5. Social Security Number 6. Sex 7. Age (i	n yrs. last birthda	Elktor	1 If Under 24 Hrs.	8. Date of Birtl	Cecil	thplace (State or Foreign
	Funeral Director		4□M 2□E	70 Yrs.	Months Davs	Hours Min.	(Month, Da) Oct.26,	(, Year) C	ountry) rginia
р	17.0		Usual Residence of Decedent					1	10d. Inside City Limits
arylar	show	٦		Oc. City, Town or					1X Yes 2 No
the M	28a-f	Director	Maryland Cecil 10e. Street and Number	Port	Deposit 10f. Zip Code			10g. Citizen of What C	ountry?
with	3a or	io le	15 Willow Drive		2190	04		USA	
death	ems 2	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
U KIKID-0000 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widdel Examinet must be notified at once.	<u>م</u>	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:			hite
72 ho	natur dical l	Completed	15. Decedent's Education (Specify only highest grade completed)	1 (Gi	cedent's Usual Occupa	luring most of worki	ng	16b. Kind of Business	/Industry
vithin	than "	du	Elementary/Secondary (0-12) College (1-4or 5+)	life	e. DO NOT use retired farmer)		farming	
filed	Hygie other ent, t		12 U		Tarmer	18. Mother's Name	(First, Middle,		
ad be	Aental rked o tic ev	To Be	Irvin Asbury			Cather	ine Mat	thews	
2 shot	and N is ma auma		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street a	and Number or Rura	al Route Numbe	er, City or Town, State,	Zip Code)
and s	tealth		Helen L. Turbett (sister) 20a. Method of Disposition		Willow Dr. sposition (Name of		posit,	MD 21904 20c. Location - City of	r Town. State
ages (ent of H		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	rematory or other plac			West Chest	
mit. P.	ortme ortan Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serviçe Licensee		ris & Co. 22. Name and Addres			-	
ă ā	Depar Impor any Ir		*Kursen Unuslingel	espea	Aberdeen,	Maryland	21001-3	399 ruileta	l Home, P.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition resulting in death)	LOYES	pirati	JYY =	farte	ive	
	Medical caminer		Due to (o) as a c	onsequence of):	- 50	1			
~		ner	se uents y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the cond	onsequence of):					
ecuted	and transi	Examiner	Cause (Disease or injury that initiated events coulding in death) Last	15					
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ath cert	ttending or use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth 2	Fetal death	3 Ectopic pregnanc	y		23d. Date of de Month	elivery Day Year
te de	by the a	hysic	1 Yes 2 No 9 Unknown	ne or death	5 ☐ Other (specify) _				
S, T	gned t	by PI	Part II. Other significant conditions contributing to death but r	not resulting in the	e underlying cause give	en in Part I.		obacco use contribute	
ecords law requires	een si		Carpiac oysryt	hmi	<u> </u>		1 🗆 \	fes 2□No 3□F	Probably 4 Unknown
e law I	has b e 2 sh	Completed	Failure to They	126			24a, Was autop		autopsy findings available completion of cause of
<u>ה</u> ב	ficate r, pag		Ambutatory DYS 25. Was case referred to medical	Func	ction	26. Place of Deat	1 ☐ Yes	2 No 1 ☐ Ye	
VITAI /siclan:]	s certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpa	atient 3 DOA Oth	or:		dence 6 ☐Other (Sp	ecify)
n Of	fter th	D:L	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day.)	(ear) 28b. Tim	ry Worl	y at	28d. Describe I	now injury occurred	
SIO	leath. tor: A the fu	catio	2 Accident investigation	At home form		Yes 2 □No	29f Location (Street and Number or F	Rural Pouto Number
DIVISION I or Attending	after of Direct d in by	Certification:	4 Homicide determined 286. Place of injury building, etc.	(Specify)	, street, factory, office		City or Tov	vn, State)	iurai risute ivuinisei,
Hospita	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/o	leath occurred at the tiper investigation, in my continued in the continue	me, date and place ppinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
To the	within To the compl	Me	29b. Signature and title of certifier	-	29c. Licens	2590	701	29d. Date signed (Mor	nth, Day, Year)
			30. Name and address of person who completed cause of dea	th (Item 23a) (Tv	pe, Print) Peg	10010		211110	
			Muhammed Nia	2-5-	Coffee	e AV	e, N	ewark;	DE 19711
	Sta		31. Date filed (Month, Day, Year) September 1997 32. Registraria	Signature	Darked		L -	7	
	Registi	alr	LED O O COOS CALLED	10. 6					

State of Maryland / Department of Health and Mental Hygiene 05266 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month **Physician** William Lee Aud 3:12 P M February 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick 5772 Hannover Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 45 Months Days 1⊠M 2□ F 217-94-0985 Maryland November 27, 1963 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21703 5772 Hannover Court United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examine and. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Sevanich William Eugene Aud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Helen S. Aud / Mother 5772 Hannover Court, Frederick, Maryland 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory 16, 2009 Smithsburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Years **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a nunseiguence uffi the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Š Cerebral Vascular Accident; Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☐ No 2K No 1 ☐ Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1XIYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 16, 2009 D37197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan H. Rohrer, D.M.E., 15 West Sventh Street, Frederick, Maryland 21701-4501 31. Date filed (Month, Day, Year) 32 Registrar's Signature State EED 9 0 2009 Backed Registrar

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 7:25 A M February Louise Boone Charlotte /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb. 22, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) 1921 Maryland Months Days Hours 1 □ M 2 1 F 87 Director 213-12-7024 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be rudflied at once. 1 ☐ Yes 2√☐ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21704 8927 Baltimore Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 ∭ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. Specify: þ White 3 ₩idowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Staub Jacob F. Altvater ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11824 Hunt Club Road, Thurmont, MD 21788 19a. Informant's Name/Relationship (Type. Print) Bonnie Clabaugh / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 2/6/2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 ounts 23a. Part Finter the disease or complications that caused the death. Do not enter the mode of dy shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 □No 1 □Yes 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State

The law requires that the death certificate be executed Box 68760, Ö Records, Division of Vital

Baltimore, Maryland 21215-0036

Registrar

cause of death (Item 23a) (Type, Print) 30. Name and address of person who

02-04-0

MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28a-b Region Maryland Department of Health and Mental Hygiene 0 9 05269 1- State Registrar 2-11-09Amend#27.PerMEPGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Darryl Anthony Barnes 01 25 2009 18:10p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 0 40 7 26 7 19 60 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F Days Hours Min 48 Director 579-86-8757 WashingtonDC Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f st traumatic event, the madical Examination must be mailfied Fort Washington Director Prince Georges MD 1 ☐ Yes 2 ☑ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene.

Is marked other than "natural", or items 23a or it 9006 Rollingwood Drive Funeral 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No <u>≥</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Specialist Telecommunication Elementary/Secondary (0-12) College (1-4or 5+) Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Raymond Barnes Carol Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 74419a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. 9006 Rollingwood Dr. Ft. Thelma Barnes/wife Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burian S ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 2/10/09 Cheltenham Veterans Cheltenham, MD 21. Signature of Juneral Service Listins 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Wash DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) nen /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death P.O. P 5 ☐ Other (specify) the ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by the detacher Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury F.n. Month, Day, Year) 27. Manner of Death 28b. Time of **Fnd**jury 28c. Injury at Work? 28d. Describe how injury occurred it is Division 1 □ Natural ending investigation Jan 24.09 12:28 ours after death.

neral Director: A
filled in by the fu death. 1 □Yes 2 🖼 No 2 Accident 3 X Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) GOOG Rollingwood De To the Hospital o within 24 hours aff To the Funeral Di completely filled in home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) EVENIS State FEB 0 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Vivian M. Cardinale February 03 2009 11:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 145 Willis Street Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1919 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 □XE 89 407-07-2548 KY Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 28a-f show aţ 1X Yes 2 No be notified Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or 21157 145 Willis Street USA Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1. ☑ Yes 2 ☐ No WWI Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than " College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If Item 27 is marked other than ury or other traumatic event, the M Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Potts Martha Craycraft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romolo J. Cardinale/husband Westminster, MD 145 Willis Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot IX Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/2009 4 Donation 5 Dother (Specify) Westminster Cemetery Westminster, MD 21. Signature of uneral Service Licensee Printend Peneral Mome and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed signed by the attending physician and I be detached for use as the burial-tran Box 68760 Physician/Medical ası IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? 1☐ Yes 2∰No page certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. I Division or Vital Records,

> WJL 4+1VA

30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) STONER AUE WESTHINGTER TOWN FREIS 295 MD KH AUL 31. Date filed (Month, Day, Year) 32. Redistrar's Signature FEB 0 5 2009

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Edgar Caicedo February 10:20A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7602 Finns Lane Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number Sex 1∆ M 2□ F 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Apr 21, 9. Birthplace (State or Foreign Country)
Colombia, SA **Funeral** Director 081-46-2655 81 1927 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fine 23s or 28s-f show important: If fine 27 Is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ha "hocital Examiner mail to norfitte) at Director 1 □Yes 2 No MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7602 Finns Lane 20706 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Yos 2□No Specify: þ Specify: White 3 Widowed 4 Divorced Colombian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic Truck Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Alfonso Caicedo Maria Sofia Quijano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Caicedo/wife 7602 Finns Lane Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State W. Arundel Crematory | 02/06/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown 9 Linknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, p 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29c. License number and title of Zertific 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 06 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05272 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6, Dorothy Rebecca Clark February 2009 08:22 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Singerly Manor Assisted Living E1kton Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2**X** F Months Days Hours Min Director 168-20-2541 83 Sept. 19,1925 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nothined at Director 1 XYes 2 No Maryland Cecil E1kton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 41 Bridgewell Parkway 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, Ire Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Housing U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malcolm G. Clark ဂ Mary C. Schmidtinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria McCool / Daughter 1237 Elk Forrest Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State 1 ☐ Burial 2xSyCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 7, 2009 Newark, Delaware 21. Signature of Funeral Service Ho 22. Name and Address of Facility Crouch Funeral Home VIC 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ladder Cancer **Physician** Unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Ves 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00023322 Jack der 5 mb 2,6.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhan MD21921 5.5 SACHDENMD 1264 E Cecil Ave 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 9 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2,2009 Februar Day **Physician** Eddie Crosby Jr. 2:00PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/22/1945 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F 63 Yrs. WashingtonDC 579-54-8050 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Marylar 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐No Prince Georges MD Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 4555 Kinmount Road IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Black Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) Supervisor

| Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | Supervisor | S 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Utility Company Elementary/Secondary (0-12) 12th College (1-4or 5+) Customer Service Washington Gas 17. Father's Name (First, Middle, Last)
Eddie Crosby Sr. 18. Mother's Name (First, Middle, Mai Naomi Gardner Pages 1 and 2 should be nent of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4555 Kinmount Rd Lanham, MD 20706 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Dornetha Crosby/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 2/7/09 Landover, MD 21. S nature of Funeral Service Licens 22. Name and Address of Facility 420 H St NE BK Henry Funeral Chapel Wash, DC 20002 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** Ruspiration /Medical Due to (or s a consequence of) Examiner meumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a sequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No certificate 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manper of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Baltimore, Maryland 21215-0036

P.O. Box 68760

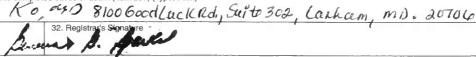
Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) FEB 0 9 2009

Horses

29b. Signature end title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ko

within 2 To the I

29c. License number

22111

29d. Date signed (Month, Day, Year)

2/2/09

	1.	For State Registrar		State	of Mai	-		tment of H ficate of I				jienę/ leg. No.	009	05271	
nysician	1.	Decedent's Name	e (First, Middle,	CRALL	E						2. Date of Dea Month EBRUAR		2009	3. Time of Death 5:40 P	
Medical caminer	4a	. Facility Name (If				ME	•	lb. City, Town, or LANHAM	Location	of Death			County of Deat		
neral ector	L	Social Security No.	1235	i.Sex 1 □ M 2√□ F	7. Age 98	(In yrs. last birt		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	Co	hplace <i>(State or Foreig</i> untry) ISBURG	
# 7	10	sual Residence of Da. State	10b. County			10c. City, Town		tion						10d. Inside City Limits	
a noulling	10	MD De. Street and Nun		E GEORGE	. 2	BOW	LE	10f. Zip Code				10g. Citiz	g. Citizen of What Country?		
any injury or other traumatic event, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	•	12601 W(I. Marital Status 1 ঐNever Marrid 3 □ Widowed	ed 2 Marrie	12. Was De	Forces? 2 A No Sive		lf Y	2072 Is Decedent of H es, specify Cuba	ispanic O	in, Puerto F	cify Yes or No- Rican, etc.)	1.	USA 14. Race - American Indian, Black, White, etc. Specify: BLACK		
Completed		(Speci		grade completed	(1-4or 5+		Deceder (Give kri life. DC	nt's Usual Occup nd of work done of NOT use retired ACCOUNT	during mo f)		g		d of Business/	•	
To Be Co	17	ALFRED (est)						er's Name ETTY	(First, Middle, ANN	Maiden S			
r trauma		9a. Informant's Na			-			Address (Street a							
ry or other	20			B □Removal from	n State		y, crema	ion (Name of tory or other plac CREMAT)		2/7/2	2009		ation - City or RDALE, M	Town, Stete [ARYLAND	
eny inju once.	2	1. Signature of Fu	neral Service Li	censee	`			Name and Address		CONTRACTOR				AL HOME	
rial-transit lical lical lical Examiner	Ir d	3a. Part1. Enter the shock, or head mediate Cause (isease or condition asulting in death) equentially list contains, bearing to improve the same contains and ause (Disease or in shock, and the same (Disease or in shock, and in the same (Disease or in shock, and in the same (Disease or in shock, and in the same (Disease or in shock, and in the same (Disease or in shock, and in the same s	nt failure. List or (Final n nditions, integrate priving	a. Due to	each line	consequence of	ru of):	Bre		s cardiac or	respiratory an	est,		Approximate Interval Between Onset and Death	
dical Examir	th re	at initíated events esulting in death) L		c. Due to	o (or as a	consequence of	consequence of):								
Page 2 should be detailed in use as Completed by Physician/Mec		FEMALE: 3b. Was decedent in the past 12 1 Yes 2 4 9 Unknown	months?		birth 2 gnant at ti	f pregnancy Fetal death me of death		ctopic pregnancy other (specify)	,			2:	3d. Date of del Month	ivery Day Year	
ed by Ph	Pa	art II, Other signif	icant condition	s contributing to	death but	not resulting in	the und	erlying cause giv	en in Part	ŧ.	23e. Did to		se contribute to	the cause of death?	
page 2 sno	-										24a. Was autop perfor	sv	prior to death?	topsy findings available completion of cause of	
irector.	25	5. Was case reference examiner? 1 ☐ Yes 2 🛣		Hospital:	Inpatien	t 2□ER/Ou		oci pos i Oth			Check only or		C7045-1/0-1	-74.1	
led in by the funeral dire Certification; To	27	7. Manner of Death 1 Natural 2 Accident		28a. Date (Mo	e of Injury onth, Day	28b. T		3 DOA 28c. Injun Wor M 1	y at	2	ne 5 🗌 Resid 8d. Describe h			ciry)	
completely filled in by the funeral director, page 2. Medical Certification; To Be Compl	2	3 ☐ Suicide 4 ☐ Homicide 9a. Certifier (Check only)	determin	ed 286. Plat buil	he best of	y - At home, far (Specify) my knowledge	, death o	occurred at the tin	ne, date a	nd place, a	City or Tow	ause(s)	and manner as	stated.	
completely file	2:	9b. Signature and		reminer: On the and ma	basis of earner state	ed.	7	29c. Licens	e number		:	29d. Date	signed (Mont	h, Dey, Year)	
State		0. Name and address Paul # 1. Date filed (Month	A. DE	VORE	MID	ath (Item 23a) (1203 ('s Signature	Type, Pi	int)	ny fo	2014	44TTS	v:11	+ MD	20781	

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 2 Year Physician 6.55PM Sue Clubb 03 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Constal Hospice At the Lake WICOMICO Salisbur If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1□M 2፟MF Months Days Hours 91 9-11-1917 Director 246-18-5057 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int! If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 2X No Director MD Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1510 Old Joppa Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify. Specify: White ģ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician 10 Cosmetology permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Edward Sallie Gladys Wren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7745 Parsonsburg Road, Parsonsburg, Maryland 21849 Mary Sue Sens - Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2-4-2009 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Lie Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part. Enter the disease, or copy shock, or heart failure. List only o Approximate Interval Between Onset and Death Physician ARCINONA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? Yes 942No 2/**T**No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ⊟ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) +0 SPICIZ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier *TI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 2005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Huntun WAN Das la HOINIL 31. Date filed (Month, Day, 32 Registrar's Signature State park 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Operation of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay 13, Year Year 2009 **Physician** 5:00 P. M Mary Louise Cody /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 634 North Adams Street Havre de Grace Harford B. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country)

March 15, 1931 North Carolina Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2**X** F Months 77 Director 237-42-4115 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1XYes 2 No Director MD Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 634 North Adams Street 21078 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 **X**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ 3√Nidowed 4 Divorced White "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than g g Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fi of Health and Mental H I Item 27 Is marked ott Marie Galloway Cullwell Galloway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie J. Gorsch (Daughter) 411 Larkspur Drive Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 2/18/09 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signaturé of Funeral Serviçe Lipensee Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chilling Physician disease or condition resulting in death) /Medical Due to (or as a conse uence of) Examiner obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine him wh sician and burial-transit death certificate be executed Due to (or s a consequence of) physician sthe burial Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death signed by the a P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License nymber 29d. Date signed (Month, Day, Year) DLIGH him 7-16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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NOTE

State of Maryland / Department of Health and Mental Hygiene 05277 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb 13, 2009 **Physician** 3:08am^м Cunningham Ann Margaret /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany 701 East 4th Street Cumberland Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year)
Aug 26, 1931 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F_X Yrs. MD 214-28-7013 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Cumberland MD Allegany **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 701 East 4th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NoX Specify: þ white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) American Heart receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard W. Kuhlman Kathrine (Dyche) Kuhlman မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland 10112 Golf Creek Drive Catherine Carter daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Chamation 3 ☐ Removal from State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 2/15/2009 Scarpelli Funeral Home, P.A. MD Cresaptown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pirit. Enter the dilease, or complications that cilised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sinck, or high artifulure. Use only one cause on eight fine. Approximate Interval Between Onset and Death Immediate Carrie (Final 2004 TASTAT **Physician** disease or condition resulting in doath) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence off use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) n signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □ Yes 2 🔀 Hospital or Attending Physician: filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 🗷 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JMAR WHMS -ONCOLOGY HLIDP 32. Registrar's Signature 31. Date filed (Month, Day, State

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 11:45 AM February Arthur Alysious Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 306 East Red Hill Road Conowingo If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 1943 Delaware 65 Director 222-26-1675 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre Medical Examits a must be notified at 1 ☐ Yes 2X No Ceci1 Conowingo Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21918 United States 306 East Red Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 72 hours after 1 XYes 2 □ No If Yes, Give US Army Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manufacturing Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygies 7 is marked other the Assembler Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manie Gilbert Nathan F. Davis ဂ Department of Health and Important: If item 27 is ma any Injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda L. Davis / Spouse 306 East REd Hill Road, Conowingo, Maryland 21918 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory of other p. West Nottingham Cemetery 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10, 2009 Colora, Maryland 22. Name and Address of Facility Crouch Funeral Home Fyner ervic Licensee 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 00 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☑ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RYIVA 1 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

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Physician Walter Dudley Sanuary 27, 3009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**½** M 2□ F Days Hours Months 577-36-8124 80 Director Jan 3, 1929 Washington, DC Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the "widgal Exer. with any bound. Director Maryland Prince George's Laure1 XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9000 Briarcroft Lane Funeral 20720 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status 1 ☐ Never Married 2 🗓 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linwood Dudley Annie Jones ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vienna Dudley - Wife 6275 Oxon Hill Road #102 Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee's Crematory 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 7, 2009 Clinton, MD 4☐ Donation 5☐ Other (Specify) 22. Name and Address of Facility 21. Sevature of Funeral Selvice Li Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Complications from Mediastinal Malignancy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed buriai-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) the ☐Yes 2☐No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?
Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 1 Inpatient 2XXER/Outpatient 3 □ DOA funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural n 24 hours after death, e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and tle of certifie MDD 43351 Greenbelt RD Suite U-15 College Park MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKWARA IKech 6201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Linda M. Daniels 8:42 AM 3 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1006 Mentor Avenue Capitol Heights Prince George If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XXF Months Days Hours 62 579-64-2863 Wash DC Director 03-22-1946 Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examination and once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 ☐ No Director MD Capitol Heights Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1006 Mentor Avenue 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 227 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2¥2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Specialist Pvt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roger Thompson ပ Helen Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Mentor Avenue Capitol Heights, Maryland 20743 Helen Barksdale/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 2/13/2009 Brentwood, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Lies 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed MULTIPLE STROKES and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown É Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy 1 ☐ Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) Hospital: 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Natural 1 ☐Yes 2 ☐No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours ... the Funeral Dire Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within To the

State Registrar

31. Date filed (Month, Day, Year) **FEB 0** 6 2009

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00058213

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Daniel Mary Μ. ebruary 2,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖺 F 89 579-28-5343 North Carolina **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location ar than "natural", or items 23a or 28a-f show the Medical Examination ast by notified at 1 XYes 2 No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20017 5024 - 13th Street, NE United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Vendor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental is marked John Oatha Daniel Mary Jane Greenwood ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles B. Daniel - Brother 5024 - 13th Street, NE Washington, DC 20017 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Feb 13, 2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. nature of Funeral Service Acensee 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PheumoniA 17445 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypovolemia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use es the burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has perform 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 🖾 Natural 5 Pending 2 🗆 No 1 Yes investigation 2 Accident i or Attend after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main Street suite 351, LAUREL MD STEVEN REMSEN 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 6 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05282 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Francine Louise DeNobrega February 13, 2009 10:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 Oak Tree Lane Apt. H Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗹 F Yrs Director 289-26-0983 80 30, 1929 Ohio Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at Director 1 XYes 2 No Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 Oak Tree Lane Apt. H 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h John Hill Parshall Nelly Parshall ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Pages 1 and 2 Karen D. Barklow 2 Oak Tree Ln. Apt. H Williamsport, Maryland 21795 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home m01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mantle disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗆 No 1 ☐ Yes 2 🖳 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2⊡∕No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

NIP

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 230 Month Year **Physician** 2009 TOBRUAK Dinsmore Doris Marie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner a (IVERSI) If Under 24 Hrs 8. Date of Birth June 27, Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** -^{Yea}(⁾925 Min 1 ☐ M 2 🔀 F Maryland 83 Director 219-10-1138 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural" or items 200 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Aberdeen Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 2216 Perryman Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna E. Smith August W. Severn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Thordeen Maryland 21001 19a. Informant's Name/Relationship (Type. Print) Ralph J. Dinsmore (Spouse) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chestnut Level Presby: 2/19/09 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.

Marvland 21001-3399 Quarryville, PA 21. Signature of Funeral Service Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** heimery disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZeNo 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? res 2 **1**4No certificate 2□ No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

5

DX

DHMH 17 Rev 1/2001

To the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

615

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 05284 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Philip Henry Ewing, Sr. 2009 A M February 3:06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4272 Osborne Road Dorchester Hurlock 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1X M 2 □ F 216-14-2608 Director 88 August 5,1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Dorchester Hurlock ould be filed within 72 hours after death with the I Mental Hygiene. arked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4272 Osborne Road 21643 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No 194. If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2□No 1943-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by Specify 1946 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Joseph Calvin Ewing Helen Marth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any injury or other traum once. Janet O. Ewing/Wife 4272 Osborne Road, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □ Donation Our Lady of Good Counsel 2/12/09 Secretary, Maryland 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21 Strongure of Plineral Se anuc. part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY ISCHEMIC Physician Month /Medical Examiner THEROSCLEROTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC PENAC 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 250 No 1010 BATHIC 24a. Was an autopsy performed? Yes 212 No 25. Was case referred to medical examiner? certificate 1∐ Yes or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\sum \) Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signatur ATTENDING MD D0053094 of person who completed cause of death (Item 23a) (Type, Print) MD 321 BLOOMING DALE AUE FEDSEAL INBOUD. 31. Date 32. Redistrar's Signature State Registrar

			1 - For State Registrar	State of Marylar		artment of H rtificate of L			iene g. No.200	19	05285
ı	Physici	an	1. Decedent's Name (First, Middle, Las	,				2. Date of Death	h Dav	Year	3. Time of Death
	/Medic	cal	Evelyn Irene 4a. Facility Name (If not institution, give			4b. City, Town, or		Februar	y 5, 200		1:27 p ^M
	Examin	ner	Carroll Hospice D				inster		,	rrol	1
	Funeral Director		213-20-3034	ex	. la <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, NOV 2,	1925 I		lace (State or Foreign Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	cto	Maryland Carrol	1		Wes	tminster				1 □ Yes 2X No
	th with the 23a or 28 and be no	ral Director	10e. Street and Number 1633 Old Taneytow	n Road		10f. Zip Code	21158	10	og. Citizen of Wr USA	at Coun	try?
5-0036	hin 72 hours after death with the Maryland e. an "natural", or Items 23a or 28a-f show Medical Evaniner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2★ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 □Yes 2 No	spanic Origin? (Spe h, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e	etc.
)-¢121	within 72 h iene. • than "natu fhe Medical	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, HOMEMAKET	uring most of workir	ng	16b. Kind of Busi		ŕ
and 2	illed I Hyg other	Be	9 17. Father's Name (First, Middle, Last) Russell Fritz			Tomanasci	18. Mother's Name Thelma				
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.	2	19a. Informant's Name/Relationship (ng Address (Street a	nd Number or Rura	l Route Number,			Code)
altimore,	Pages 1 a ment of He ant; If item ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cier	sition (Name of natory or other place Branch Cen	2/40/		Westmi	-	
Ball	permit. Depart Import any Inj		21. Sign ture of Funeral Service Licen	Sulvo		2. Name and Addres 91 Willis	1.1	vers-Dur Vestmins	boraw Frater, MD	uner 211	al Home 57
1	Physician		23a. Part 1. Enter the disease, or company shock or heart failure. List only immediate Cause (Final disease or condition	olications that caused the dea		er the mode of dying			est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consect				400-6			
	ecuted and transit	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	Daw to (or as a nonsec							
58760,	ificate be executed physician and sthe burial-transit	edical Ex	resulting in death) Last	Due to (or as a consec	quence of):						
POX	ath cert	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠No 9 □ Unknown	23c. If yes, outcome of pregn 1	aldeath 3[Ectopic pregnancy			23d. Date Mont		ery Day Year
S	w requires that the de s been signed by the a should be detached f	þ	Part II. Other significant conditions o	ontributing to death but not res	sulting in the u	nderlying cause give	n in Part I.		3.		e cause of death? ably 4 🔲 Unknown
•	~ 4	Completed						24a. Was an autopsy perform	/ pri ne d ? de	ere autor or to cor ath?]Yes	osy findings available npletion of cause of 2 No
VITAI	slcian certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:	1	othe	26. Place of Death				Hospice
0	g Phy: erthis eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	IL 3 LI DOM	4 LI Nursing Hon		nce 6 Other w injury occurred	` ' '	Hacility
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<u> </u>	ital or Att rs after de ral Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Speci	ify)		1	City or Town	•		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	ause(s) and man ate and place, an	ner as si d due to	tated. the cause(s)
	WJL	2	29b. Signature and title of certifier	Alliton MD		29c. License	number 443	29	2/7/2	Month, I	Day, Year)
	5		John W. Middle	completed cause of death (Ite	Victor	ry Street,	Marche	steg	MD	211	62_
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2	32. Registrar's Sign	ature A. A	backer					

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 2009 12:30 January KENNETH FLEMING /Medical AUGUSTUS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 64 220-40-9787 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exactings nount be notified at MD Frederick Mt. Airy Director 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 US 16 Grimes Court items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 **∑**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 White 1 ☐Yes 2 No Specify: Specify 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter 12 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roby Fleming Catherine May Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Fleming wife 16 Grimes Court, Mt. Airy, MD 21771 Barbara 20b. Place of Disposition (Name of cemetery, crematory or other place)

Taylorsville UMC Cem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Bynial 2 ☐ Cremation 3 ☐ Removal from State Feb 6 2009 Taylorsville, MD 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road, Winfield, MD 21784 Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Onset and Death Immediate Cause (Final disease or condition resulting in death) Aneurisms (**Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner of as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 □No 1 □Yes 2 MNo 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature itle of certifie WJL 10 no completed cause of death (Item 23a) (Type, Pript) Perich Manorial Hopse, MU 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Box 68760

P.0.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year PACITA FEBRUARY 3:40 PM GREGORIO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Months Days Hours 70 027-80-9398 Director Oct. 20, 1938 Philippines Usual Residence of Decedent the Maryland 10a, State r 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director M Yes 2 □ No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene introducing them 23a or important: if item 27 is marked other than "natural", or items 23a or important: if item 27 is marked other than "natural", or items 23a or important or other traumatic event, the Medical Examinat must be none. death with Philippines 21702 111 Bierstadt Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify 3 ☐ Widowed 4 ☐ Divorced <u>Asian</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eulalia Egdanes Ceferino Eribal ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Bierstadt Court, Frederick, MD 21702 Luis Gregorio / Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/9/2009 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Fert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** per kalencia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End Stage R Due to (or as a consequence of): Rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 📉 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (ma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 □ Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifics funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2/3/09 sal 067657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anish Desai 400 West 7th Street, Frederick, MD 21701 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - State Registrar		Certificate of Death	Reg.	No.	
	Physici		1. Decedent's Name (First, Middle, Last SIDNEY A	ALFRED GREENWAY		2. Date of Death Month FEBRUARY	Day Year 6 , 2009	3. Time of Death 3:52 A
Š	/Medio Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	xa	•	7415 Farmcrest Dr	ive	New Carrollton		Prince	George's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		
	Director		577-34-6265	M 2□F 80	Yrs. Months Days Hours Min.	June 15.	1928 Nor	nplace (State or Foreig untry) th Carolin
			Usual Residence of Decedent			, ,		
	land		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Man	ģ	Maryland Prince	Genrae's	New Carrollton			tx∑Yes 2 ☐ No
	288 288	Funeral Director	10e. Street and Number	ocorge b	10f. Zip Code	10g.	. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or iteme 23a or 28a-f show event, if a Medical Examinar must be rectified at		7415 Farmcrest Drive		20784		USA	
		era		12. Was Decedent Ever in U.S.		pecify Yes or No-	14. Race - Amer	rican Indian
	item d	Ē	11. Marital Status	Armed Forces?	13. Was Decedent of Hispanic Origin? (S) ff Yes, specify Cuban, Mexican, Puerlo	Rican, etc.)	Black, White	
21215-0036	s aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates KOREAN	1 ☐ Yes 2 X No Specify:		Specify: W	hite
	hour liura	D D	15. Decedent's Ed		Decedent's Head Occupation	101	Vind of Business	
	"na"	Completed	(Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	o. Kind of Business/I	ndustry
	e filed within at Hygiene. cather than 'vent, the Me		Elementary/Secondary (0-12)	College (1-4or 5+)			A ITH C ITH	
	Hygie Hygie Ither		17. Father's Name (First, Middle, Last)	2 Co.	mmunications Enginee	e I ne (First, Middle, Mai	AT&T	
Baltimore, Maryland	be fi	To Be					,	
	should be ind Menta i marked umatic ev		Willie Frank Greenway Beatrice Garrison					
	C1 C0 = 6		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
	end selth n 27		Cynthia J. Thomas		415 Farmcrest Dr., N	lew Carrol	lton, MD	20784
	permit. Pages 1 el Depertment of Hee Important: If item eny injury or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State					
			4 Donation 5 Other (Specify		d Veterans Cemetery 2/1	9/09 C1	heltenham	, Maryland
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave.					
			Gasch's Funeral Home, P.A. Hyattsville, MD 2078					
68760,	Physician /Medical	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart faifure. List only of Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA a	ot enter the mode of dying, such as cardiac	or respiratory arrest,	st, Approximate Interval Between Onset and Death	
	Examiner		Sequentially list conditions,	Oue to (or as a consequence of): ALZHEIMER S DEMENTIA				
	uted d ansit		if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a consequence of).				
	thet the death certificate be executed ted by the attending physicien and detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of	uence of):			
		Certification; To Be Completed by Physician/Medical I						
68				v .				
Division of Vital Records, P.O. Box			IF FEMALE: 23b. Was decedent pregnanl in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at lime of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Oate of deli Month	very Day Year
	sign Sign d be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown					
	ding Physician: The law h. Ater this certificete hes b funeral director, page 2 s					24a. Was an autopsy performed	prior to completion of cause of	
						1 ☐ Yes 2 ☐	K No 1 ☐ Yes	2 🗌 No
			25. Was case referred to medical examiner?	26. Pface of Death (Check only one)				
			1 163 220110	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
			27. Manner of Death 1 Xiatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined		le of ry Work? 28d. Describe how injury occurred ny 1 Tyes 2 No			
	in Die			28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,	
	ne Hospitai n 24 hours e ne Funerei i	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge tiner: On the basis of examination and and manner stated.	duath persured at the time, date and clace d/or investigation, in my opinion, death occu	and due to the caus rred at the time, date	ie(s) and mainner as and place, and due	stated. to the cause(s)

CR 10+1

31. Date filed (Month, Day, Year)
FEB 0 9 2009

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

29c. License number

MD# 33255

29d. Date signed (Month, Day, Year)

FEBRUARY 6, 2009

			For State Registrar		State of M	laryland	l / Depa <i>Ce</i>	artment of F <i>rtificate of I</i>	lealth and Death	Mental H	ygiene Rea. No	e2009	05289
				me (First, Middle, La	st)					2. Date of E	eath		3. Time of Death
	Physici /Medic			J	ULTAN_HAR	VEY GE	ELENTE	ER		Month FEB	3 20	009	8:32 A M
	Examin	er	4a. Facility Name	(If not institution, giv	e street and number)		4b. City, Town, or	Location of Dea	ath	40	. County of Dea	
			NATION 5. Social Security	NAL NAVAL Number 6. S		ENTER ge (In yrs. las	ot hirthday)	B] If Under 1 Year	ETHESDA I If Under 24 Hr	S Q Data of E	tirth		GOMERY
	Funeral Director		057-22-	-0819 ¹	X M 2□ F	79	Yrs.	Months Days	Hours Mir		Day, Year,	1929	thplace (State or Foreign ountry) New York
	land		Usual Residence 10a. State	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary Firsh	tor	 Virginia	Fai	rfax			Fa	lls Chui	rch			1 ∐Yes 2 MNo
	h the	Director	10e. Street and N					10f. Zip Code			10g. Ci	itizen of What Co	ountry?
	23a c		3709	S. George	Mason Dr	., #13	08E	22	041-374	7		U.S	. A.
	er dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?		Was Decedent of H If Yes, specify Cuba	Ispanic Origin? (an, Mexican, Pue	Specify Yes or North Rican, etc.)	10-	14. Race - Ame Black, Whit	
35	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the "scifical Evariner must be positified at	by F		urried 2 Married 4 Divorced	1 □ XYes 2 □ If Yes, Give Year or Dates:	№ 1949 - 1974	•	1∐Yes 2⊠No	Specify:			Specify:	White
2-0036	2 hou			15. Decedent's Ed		17/4	16a. Dece	dent's Usual Occup	ation		16b. K	(ind of Business	/Industry
Z	thin 7 ie. ian "n	Completed	(Sp Elementary/Se		College (1-4or	5+)	(Give life.	kind of work done of DO NOT use retired	during most of wo f)	orking			
7	filed within Hygiene. other than '		12	(F) 1 40 10 1 1	5+			Military					es Air Force
and	ntal Fed otl	Be	17. Father's Name	e (First, Middle, Last)		2 + 2 22			18. Mother's Na	ame (First, Midda		,	
Ξ	2 should to and Meniar sand market	၀	19a Informant's	Name/Relationship (rles Gelei Tuna Print)	iter	10h Mailir	ng Address (Street a	and Number or F			ttlieb	Zin Cada)
<u>8</u>	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic			olyn Gelen		Ī		-					VA 22041-3747
ā,	s 1 al		20a. Method of D	isposition			ce of Dispo	sition (Name of matory or other place	1	Date		ocation - City or	
Ē	Pages ment of ant: If its ary or o		1 ☑ Burial 2 4 ☐ Donation	2 ☐ Cremation 3 ☐ 1 5 ☐ Other (Specif	Removal from State y)	· 1		ational Ceme		h 20, 200	19	Arlington	n, Virginia
Sattimo	permit. Page Department Important: I any injury o		1. Signature of I	Funeral Service Licer	nsee		22	2. Name and Addres	ss of Facility Mt	irphy Fa	11s	Church	Funeral Home
_	205 2		Jan	nuch.	fliai			102 west				urch, V	A 22046
			shock, or he	r the disease, or con- eart failure. List only	plications that cause one cause on each	d the death. ine.	Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
-	Physician /Medical		immediate Cause disease or condit resulting in death	tion				IAL INFAI	RCTION				Crist and Stagr
	Examiner			1	Due to (or as	a conseque	nce of):						
		Je.	Sequentially list of cause. Enter Und Cause (Disease of	onditions,	b. Due to (or as	a conseque	nce of						-
	acuted nd transil	Examiner	Cause (Disease of that initiated even resulting in death	or injury	c								
Ď,	icate be executed physician and the burial-transit	Ě	resulting in death) Last	Due to (or as	a conseque	nce of):						
58/50,	tificate be executed g physician and as the burial-transit	edical			d								
DOX	certific	/Me	IF FEMALE: 23b. Was decede	ant program	23c. If yes, outcome	e of pregnance	су					23d. Date of de	liven
ă	death e atte d for u	icial	in the past 1 1 ☐ Yes 2	2 months?	1 ☐ Live birth 4 ☐ Pregnant			☐ Ectopic pregnancy ☐ Other (specify)	/			Month Month	Day Year
л. Э	Physician: The law requires that the death cerr this certificate has been signed by the attending director, page 2 should be detached for use a	Physician/M	9 ☐ Unknow		9 Unknown								
'n.	es the igned	β	Part II. Other sign	nificant conditions o	ontributing to death I	out not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ecords	requir	ted								1	Yes 2	MNo 3□Pi	robably 4 🗌 Unknown
S E	e law has b	Completed									opsy	prior to	itopsy findings available completion of cause of
0	n: Th ficate r, pag		05.114							1 □ Yes	formed? 2 No	death? 1 □ Yes	2 □ No
NI S	sicial s certi lirecto	Be c	25. Was case reference examiner? 1 ☐ Yes 2	i	Hospital:	ent 2 ☐ EF	D/O-4+i	Othe		eath (Check only			
lo uoi	g Phy er this	n: To	27. Manner of Dea	ath	28a. Date of Inj	ury 2	8b. Time of	IL 3 LI DOA	4 LI Nursing	28d. Describe		6 ☐ Other (Spe	cify)
2	ath. ath. r: Aff	atio	1 XNatural 2 Accident	5 ☐ Pending investigation		ay, rear)	Injury		? ∕es 2 □ No				
<u> </u>	or Atte ter de irecto n by ti	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of in	jury - At hom tc. (Specify)	e, farm, str	eet, factory, office			(Street ar		ural Route Number,
ב	pital o		On Continu	4E 0- 45 - Pt									
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier (Check only one)	152 Certifying Ph 2∐ Medical Exam	nysician: To the best niner: On the basis and manner s	of examinatio	edge, deat on and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time	e cause(s e, date and	s) and manner a: d place, and due	s stated. to the cause(s)
	Vithi Comi	Ž	29b. Signature an	d title of certifier	Ra D.	m		29c. License	number		29d. Da	te signed (Mont	h, Day, Year)
	201		1/1	1) ment) yaca				04A (IN)		Feb	,4,20	009
12	2 1/			dress of person who		_	3a) (Type, USN	Print)				L MEDICA 0889-560	AL CENTER
	Sta							 -		THEOUA	<i>اک ب</i> دید	2003-200	/1/
	Registra	ar .	FERV	U 2003 /4	de man	7							

State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14, **Physician** Fe.bruary 2009 Groner 1850 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 209 Alliance Street Havre de Grace Harkord If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
J. (Month, Pay, Year) 943 New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖸 F 65 146-32-4070 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits works ir than "natural", or itama 23a or 28a-f shov the Medical Examinar must be molified at 1 ¥Yes 2 No Director Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Alliance Street 21078 United States of America within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Retail Sales and Mental Hygier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Vacchiano Marie Van Note 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Importent: if item 27 ia.
any injury or other trans Stephen Groner (Son) 55 Garden Avenue, Brick, New Jersey 08724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 02-19-2009 Monmouth Mem. Park * 4 ☐ Donation 5 ☐ Other (Specify) Tinton Falls, New Jersey 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service 123 South Washington St. Havre de Grace, MD 21078 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Privsician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, leading a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🗆 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. scribe how injury occurred Certification: Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours at To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed Homas 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registrar

Barre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			1 - State of Maryland /		tificate of D			ene 2 U U S	05291		
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death		
	/Medic	cai	Dorothy Z. Herbold				February	2, 2009	10:48 A ^M		
	Examin	ner	4a. Facility Name (If not institution, give street and number) Northampton Manor		4b. City, Town, or L Frede			4c. County of Death Frederick			
• *	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs.					
	Director		218-40-8048	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 27,	1919 Maryl	and		
	yland yland		10a. State 10b. County 10c. City, Tov	wn or Loc	ation			1	0d. Inside City Limits		
	e Mar 3a-f sl	Director	Maryland Frederick	Wa1k	ersville				1X Yes 2 □ No		
	ith th	Dire	10e. Street and Number	·	10f. Zip Code		109	g. Citizen of What Cour	itry?		
	s 23a	eral	260 Providence Circle	1		793		United Stat			
30	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be incitified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	/as Decedent of Hisp Yes, specify Cuban, □Yes 2∑No	panic Origin? (Spe , Mexican, Puerto <i>Sp</i> ec <i>ify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	etc.		
215-0036	2 hour	ted	15. Decedent's Education 16	a. Deced	ent's Usual Occupati	ion	16	5b. Kind of Business/Inc	Thite dustry		
212	thin 7; e. an 'h	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	rind of work done dui O NOT use retired)	ring most of workii	ng				
7	e filed wi al Hygien other th vent, the	S	5+	Scho	ol Teache			Board of E	ducation		
⊆	ev d stal	Be	17. Father's Name (First, Middle, Last)		1		(First, Middle, Ma	aiden Surname)			
<u>-</u>	2 should and Mer is marke aumatic	၉	Harry Ziegler 19a. Informant's Name/Relationship (Type. Print) 19	h Mailin	Address (Street an		Minton	City or Town, State, Zip			
	alth a							ville, MD 2			
e.	es 1 au of Hea fitem rothe		20a. Method of Disposition 20b. Place cemet	of Dispos	ition (Name of atory or other place)	D	ate 20	c. Location - City or To	wn, State		
Ē	Pages ment of ant: If it ury or o		T Durial 2 by Cremation 3 Linemovaritom State		Cremator		2009 F	rederick, M	aryland		
Baltimor	permit, Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee		Name and Address			Funeral Ho			
	e o		Tomprey Staufer				_	ederick, MD			
			23a. Part 1 Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not ente	r the mode of dying,	such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death		
No. of Section	Physician /Medical		disease or condition resulting in death) a. Alzhei m evs		rsease				years		
1	Examiner		Due to (or as a consequence	e or):					,		
	p #	ner	Sequentially list conditions, if any, leading to immediate Cause Cisease or injury that initiated events Cause (Disease or injury that initiated events C	of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
00/00	rtificate be executed ng physician and as the burial-transit	al E	Due to (or as a consequence	e of):				i.			
00	tificate ig phys as the	/ledical	d								
Š	th cert	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal deat	. a 🗆	Catania augustas			23d. Date of delive	ry		
5	irres that the death cer signed by the attendir d be detached for use	Physician//	in the past 12 months? 1		Ectopic pregnancy Other (specify)			Month	Day Year		
ŗ	that the by detac		Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given	in Part I.	23e. Did toba	cco use contribute to th	e cause of death?		
Solus,	Physician: The law requires that the death ce this certificate has been signed by the attending director, page 2 should be detached for use	ed by					1 ☐ Yes	2 No 3 □ Prob	ably 4 ☐ Unknown		
<u>.</u>	i: The law require icate has been si ; page 2 should b	Completed					24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of		
<u> </u>	icate l	Co					performe 1 □ Yes 2	d? death? ¶No 1 □ Yes			
5 :	ysician: The sistem of the control o	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othori	6. Place of Death					
5 7	ding Phys 7. After this funeral di	7: 70	27. Manner of Death 28a. Date of Injury 28b.	utpatient Time of	3 LI DUA		ne 5 Residence 8d. Describe how	ce 6 Other (Specify)		
5	ath. r: After e funer	atio	1 Matural 5 ☐ Pending (Month, Ďay, Year) 2 ☐ Accident investigation	Injury	28c. Injury a Work? M 1 □ Yes	s 2 No	od. Doddilbe flow	many occurred			
2	or Atter ter dea Irecto In by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rurai State)	Route Number,		
ָּ	ontal o		200 Codeffee								
	I to the hospital or Attending Ply within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge and manner stated.	je, death nd/or invi	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)		
	vithii To th	Me	29b. Signature and title of certifier		29c. License n	umber	29d	. Date signed (Month, L	Jay, Year)		
					D4:	3091		2-3-09			
1	4)		30. Name and address of person who completed cause of death (Item 23a) Society Third MD 8 31. Date filed (Month Day Year) 32. Refistrar's Signature	(Type, P	ou Hor	use A	ve, Fr	ederick,	MD		
	Stat Registra	te ar	31. Date filed (Month Pay Year) 32. Redistrar's Signature	. 1	arkel	· · · · · ·					
				1							

			1 - State of Maryland / Department of State of Maryland / Department of Certificate			liene 2009	05292
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	Day Year	3. Time of Death
,	/Medio Examir		Claudette M. Herder 4a. Facility Name (If not institution, give street and number) 4b. City, To	wn, or Location of De	Februar ath	4c. County of Dea	
,			Fort Washington Health & Rehab Center For 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	<u> </u>			George's
ı	Funeral Director		579-68-4756 1□M 2♥F 71 Yrs. Months □	ays Hours Mi			thplace (State or Foreign ountry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mary Ba-f sh	Director	Maryland Prince George's Suitland				M∑Yes 2 □ No
	with the 3a or 2	al Dire	10e. Street and Number 10f. Zip Co 2074			Og. Citizen of What Co United Sta	•
36	be filed within 72 hours after death with the Maryland ital Hygiene. In the Hygiene, of other than "natural", or items 23a or 28a-f show event, I'm Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 V	t of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	72 hour natural lical E	eted !	15. Decedent's Education 16a. Decedent's Usual C	ecupation	and the second	16b. Kind of Business	
121	within and the than "I	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use r	lone during most of we etired)		0	
nd 2	< _ m o	Be Co	12 years Administra 17. Father's Name (First, Middle, Last)		ame (First, Middle, N	Governme Maiden Surname)	nt
Maryland	should be fand Mental s marked o	일	Bruce E. Herder		E. Brown		
	as 1 and 2 should b of Health and Ment I Item 27 Is marked r other traumatic e		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S 1136 Kennel				
Baltimore,	Pages 1 ar nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 □ 20b. Place of Disposition (Name cemetery, crematory or other			20c. Location - City or	Town, State
	permit. Pages Department of Important: If It any Injury or o		4DDonation 5 □Other (Specify) Cedar Hill Ceme			Suitland,	
ñ —	Deprime any		A Land Control of the			uneral Hom ington, DC	
	Dharataian		23a. Part\—Enber the disease—or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line. Immediate Cause (Final	f dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Breast Cancer Due to (or as a consequence of):				
	Examiner	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b				
	acuted ind transit	Examine	that initiated events				
68760,	rificate be executed ig physician and as the burial-transit	ial Ex	resulting in death) Last Due to (or as a consequence of):				
		Medical	IF FEMALE:				
C. BOX	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preging the pregnant at time of death 5 Other (specification)			23d. Date of del Month	ivery Day Year
S,	gned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	requir been si hould b	eted			1 □ Ye	s 2⊠No 3⊟Pr	obably 4 🗍 Unknown
vitai Ret	in: The law lifficate has or, page 2 s	Completed	25. Was case referred to medical		24a. Was an autopsy perform 1 □ Yes 2	prior to death? □MNo 1 □ Yes	topsy findings available completion of cause of 2 ☐ No
5	hysicle his cer I direct	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other	eath (Check only one Home 5 Resider	nce 6 □Other <i>(Spe</i> e	cifv)
=	ding P h. After t funera	E i		Injury at Work?	28d. Describe how		
DIVISION	al or Atten s after deat al Director: ed in by the	Certification: To	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined	1 □Yes 2 □No ce	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the desired of the desired form of the des	ne time, date and place my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
V	Vithi Com	Ž		ense number 5206		d. Date signed (Month February 4	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ad Trans II	a a b d == + =	MD 207//	
	Stat	٠	William T. Tanner, M.D. 11701 Livingston Ro	au fort W	asuington	, MD 20/44	
	Registra		ELM II IN /INIT! / NEWAY OF APPEA				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar		(Certificate of	Death		Reg. No. 2 (009	0529
ysician	1. Decedent's Name (First, Middl					2. Date of De Month	Day	Voor	Time of Death
Medical	Darrell Ray Ho					02	02		1625P M
kaminer	4a. Facility Name (If not institution PENINSAUA REGIO			4b. City, Town,	or Location of Death)	4c. County of Death		
neral	5. Social Security Number	6. Sex 7. A	Age (In yrs. last birth	day) If Under 1 Year		8. Date of Bir	th I	9. Birthplace	(State or Foreign
ector	301-76-3547	1 ½ M 2□F	43 Y	rs. Months Days	Hours Min.	March 2	1, 1965	Ohio	
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. In	nside City Limits
Examiner rount be notified at I by Funeral Director	DE Sus	sex	Delma	r				1	□Yes 2 No
Director	10e. Street and Number	BCX	Бетика	10f. Zip Code			10g. Citizen of V	What Country?	
al D	6239 Delmar Ro	ad		1994	0		U.S.A.		
Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Rac	e - American Inck, White, etc.	dian,
by Ft	1 Never Married 2 Mar	ried 1 ☐ Yes 2 ☑ If Yes, Give	3 No	1 □Yes 2 😿 No			Specify		1-
D D	3 ☐ Widowed 4 XX Divorced			Secondantia Haval Occu	ingtion			D L a	ack
Slette	(Specify only highe	t's Education st grade completed)	(Decedent's Usual Occu Give kind of work done life. DO NOT use retire	apation e during most of wor ed)	king	TOD. KING OF BU	isiness/maustry	
Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Plumber	-,		Plumb	ing Com	ipany
once. To Be Completed by	17. Father's Name (First, Middle,	Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surnam	ne)	
2	Frederick Holl	ins			Barbara	Todd	_		
	19a. Informant's Name/Relations			Mailing Address (Stree		<i>ıral R</i> ou <i>t</i> e Numb		State, Zip Code	3)
	Williamanna C.	Hill (Comp		9 Delmar R		mar, DE	19940		
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Removal from Stat	e 20b. Place of I cemetery	Disposition (Name of crematory or other pla	ace)	Date	20c. Location -	City or Town, S	tate
	4 □ Donation 5 □ Other (S		Cremato	ry of Delm		7,2009	Delmar	, Delaw	are
	21. Signature of Funerel Service	Licensee		Short Fu	neral Hom	ie .	DM	100/0	
	23a. Pert 1. Enter the disease, or	complications that caus	ed the death. Do no		ove Stree			App	roximate
	shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.		14,000	1		Inter Ons	val Between et and Death
	disease or condition resulting in death)	Due to (or e	as a consequence of	WE/	Typee	jen	ann		
					1				
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	a consequence of):					
xaminer	Cause (Disease or injury that initiated events resulting in death) Last	с							
ш	resulting in death) Last	Due to (or e	s a consequence of):					
dica		d							
Physician/Medical	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d Dat	te of delivery	
ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				nth Day	Year
hysi	9 Unknown	9 ☐ Unknowr	7						
by P	Part II. Other significent condition	ons contributing to death	but not resulting in t	he underlying cause gi	iven in Part I.	23e. Did t	obacco use cont	ribute to the cau	ise of death?
ed	ON STA	fe he	nax	HATE		1 🗆 '	/es 2□No	3 ☐ Probably	4 Unknown
ple		/				24a. Was autor		Were autopsy fi	ndings available
Completed				V		perfo 1 ☐ Yes	rmed2	death? 1 □Yes 2 □ I	
Be	25. Was case referred to medica examiner?		4	To:	26. Place of Dea	th (Check only o	ne)		
2:	1 Des 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of Ir	-/-	atient 3 DOA			dence 6 Oth		
tion	Matural 5 ☐ Pendin	g (Month, L		ury Wo	uryat ork? ⊒Yes 2 ⊒No	Zou. Describe i	now injury occurr	cu	
fica	3 Suicide 6 Could	not be 28e. Place of I	njury - At home, farr	n, street, factory, office		28f. Location (S	Street and Numb	er or Rural Rou	te Number,
Certification: To	4 ☐ Homicide determ	building,	etc."(Specify)			City or Tov	vn, State)		
completely filled in by the funeral director, page 2 should be detached in Medical Certification: To Be Completed by Physic	29a. Certifier (Check only Medical	ng Physician: To the best	t of my knowledge,	death occurred at the	time, date and place	e, and due to the	cause(s) and ma	anner as stated	
₩.	one)	and mariner		o. mwosuganom, m my	opinion, death occi	og at the time,	cate and place,	and and to the t	(2)
<u>a</u>	29b. Signature and title of certifie				nse number	T	29d. Date signe		

State Registrar 31. Date filed (Month, Day, Year)
FEB 0 6 2009

29c. License number

DR. Kazi Khan

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 05295 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LULA MAY HARDING FEB.13,2009 12:57P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MD.HOSPITAL CENTER CLINTON PRINCE GEORGES 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-29-1920 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F 578-18-0026 88 Director VA. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director MD. CHARLES WELCOME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8315 DASHING PLACE 20693 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XTo Specify: ģ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RESTUARANT WAITRESS 12th Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic servers. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) RUBEN CHARLES ATKINS ပ DAISY MAY WOODARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES F. HARDING, JR. - SON | 8315 DASHING PL. WELCOME, MD. 20693 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

TRINITY MEM. GARDENS 2-19-09 WALDORF, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PIATA, MD. 20646 21. Signature of Funeral Service Licensee M00479 23a. Part1. Enter the disease, or complication that caused the dea shock, or heart failure. List only one cause of ach line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Death 28a. Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? e Hospital or Attending P 124 hours after death.
e Funeral Director: After t letely filled in by the funera 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who com-Print) 750 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Called

DHMH 17 Rev 1/2001

Registra

		Plea	se Type or								egible.			
		For State Registrar		ı Marylar		ertificate	of Health an of Death	na ivie	entai Hyg Re	ene g. No. 2	009	05296		
Physicia	an	Decedent's Name (First, Middle	·					2	. Date of Deat Month	n Day	Year	3. Time of Death		
/Medic			Richard		lutting	3			Februai		, 2009	0850 A ^M		
Examin	er	4a. Facility Name (If not institution		mber)		4b. City, Tow	n, or Location of D	Death	h 4c. County of Death			n		
		520 Franklin S					ryville			C	ecil			
Funeral Director		5. Social Security Number 267-64-7460 Usual Residence of Decedent	6. Sex 1	7. Age (In yrs.	. last birthday Yrs.			Min.	Date of Birth (Month, Day, ay 12,	Year) 1944	Co	nplace (State or Foreign untry) Jersey		
land ow		10a. State 10b. County		10c. Ci	ity, Town or L	ocation			10d. Inside City Lim					
Mary f sh	ţō	Marvland Cec	: 1	D	erryvi	110				1 X Yes 2 □ No				
h the Maryland rr 28a-f show	Director	10e. Street and Number	L <u>T</u>		CILYVI	10f. Zip Cod	de		11	10g. Citizen of What Country?				
3a or	<u></u>	520 Franklin St	reet			219	N 3				ited S	,		
vurs after death with the Maryland ral", or items 23a or 28a-f show Evanings must be notified at	Funeral	11. Marital Status	12 Was Door	edent Ever in U	J.S. 13.	Was Decedent	of Hispanic Origin	n? (Speci	fy Yes or No-		Race - Ame			
or ite		1 ☐ Never Married 2 ☐ Marr	cu i Mico			_	Cuban, Mexican, P	Puerto Rio	can, etc.)		Black, White	, etc.		
	Completed by	3 🎇 Widowed 4 □ Divorced	If Yes, Gi Year or D	ve War		1 □Yes 2 💢	No Specify:			Sp	ecity:	hite		
72 hours 'natural",		15. Decedent (Specify only highes	's Education		16a. Dece	edent's Usual O	ccupation one during most of	f working		16b. Kind o	of Business/I	ndustry		
ithin ne. han "	du du	Elementary/Secondary (0-12)	College (*	-4or 5+)	life.	DO NOT use re	etired)	Working						
led w lygie her tl	Be	11			In	staller					ooring			
be fi		17. Father's Name (First, Middle,	Last)						First, Middle, N		rname)			
ould J Mel narke	P_	Herman Hutting		·					Matthe					
12 st hand 7 Is n traun		19a. Informant's Name/Relations	, , , , ,				reet and Number o					ip Code)		
1 and Healt em 2		Christopher Hut 20a. Method of Disposition	cting/Son	201	520	Frankli:	n Street					00		
it of or o		1 X Burial 2 ☐ Cremation		State		osition (Name o matory or other	^r place) Fel	brua:	ry a	20c. Locati	ion - City or T	own, State		
it. Pa rtmei rtant njury		4 □ Donation 5 □ Other (Sp		As		emetery	18	, 200	09	Port	Depos	it, MD		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any injury or other traumatic event, the Medical Eva once.		21. Signature of Funeral Service I	Licensee	-	2	Hicks Ho	ddress of Facility ome for I Stockton	Funer	rals, P	.A.	MD	21921		
		23a. Part 1 Enter the disease, or	complications that c	aused the dear	th. Do not er	nter the mode of	dying, such as ca	rdiac or r	respiratory arre	st,	, MD	Approximate		
Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	ach line.	4 - 00-	112/17	Matari	far:			t	Interval Between Onset and Death		
/Medical		resulting in death)	a. Due to	or as a consec	quence of):	CUSIN	" le as	wou	/3		7	nknown.		
Examiner		0	h	•										
d ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	or as a consec	quence of):					6. *				
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oe ex	_	resulting in death) Last	Due to	or as a consec	quence of):									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Theodore Mount Jester 9:58PM Feb. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminister Carroll 8. Date of Birth (Month, Day, Year) 1920 Sirthplace (State or Foreign April 18, Delaware If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**ℤ** M 2□ F 227-18-6827 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll Taneytown 1 ZYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 305 E.Baltimore St. 21787 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces? 1.950 - 55
If Yes, Give 4941 - 46
Year or Date 4941 - 46 Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. White 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Grain & Supply Co. Manager& Pres. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Jester Jenny May Mount ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Jester - Wife Taneytown, MD21787 E.Baltimore St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Trinty Lutheran Cem.2/7/09 Taneytown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 17340 Little's FH 34Maple Ave.Littlestown.PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** IEIEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Ligary that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 perform this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) OWE HOUSE 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of e Hospital or Attending Pt 24 hours after death. e Funeral Director: After the letely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospina.
within 24 hours after
To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and litle of certifie 29d. Date signed (Month, Day, Year)

WIL

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 6 2009 Renewal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature B. Sparks

POOLE RD WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01044 State of Maryland / Department of Health and Mental Hygiene David Allan Jaquith 200<u>9 052</u>98 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1132 hrs February 4, 2009 Medical Examiner David Allan Jaquith c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Greenbelt 7216 Hanover Parkway 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Country) **Funeral** Min. Hours Months Feb 21, 1950 Waterville,ME Director 58 218-54-8296 1 X M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any. 1 X Yes 2 No Maryland Prince George's Greenbelt show the Maryland Director 10g. Citizen of What Country? 10f. Zip Code or items 23a or 28a-f: must be notified at on 10e. Street and Number USA 20770 7216 Hanover Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with t neut of Health and Mental Hygiene, anti. If item 27 is marked other than "natural", or items 23a not it if item 27 is marked other than "natural", or items 23a not other trannatic event, the Medical Examiner must be not 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 Married Never Married 2X No Yes White Specify: Yes 2 X No specify: 4 X Divorced If Yes, Give Year Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Environmental College (1-4 or 5+) Elementary/Secondary (0-12) Protection Agency Toxicologist 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard H. Jaquith Emma Bottum Department of Health and Mental Important: If item 27 is marked injury or other traumatic event Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 206 North Laura Anne Drive, Sterling, VA Robert Jaquith / Brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2 X Cremation 3 2/6/2009 Alexandria, Virginia Metropolitan Crematory Donation 5 Other Specify. 22. Name and Address of Facility 4739 Baltimore Ave. permit. gnature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, JEAN (GOZZI) Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician Death **Medical** a Complications of chronic alcoholism Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Litter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical AMENDED tending physician a use as the burial -UNPENDED Unspital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE EEMALE Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the Fetal death Live birth the attending past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown бō g Unknown Phy detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o<u>i</u> No 3 Probably 4 V Unknown Yes 2 ò σ. Completed 24a. Was an 24b. Were autopsy findings available Division of Vital Records, has been prior to completion of cause of autopsy performed? death? No 1 🗸 Yes ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 1 V Yes this 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 1 V Natural Pending death the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. by 1 Could not be or Town, State) 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

February 5, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Regis ar's Sign 31. Date filed (Month, Day, Year)
FFR 0 9 2009 State Registrar **ORIGINAL** DHMH 17 Rev 1/2001

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	10		30. Name and address of person of the state	who completed cause of	death (Item)	23a) (Type, I	LIVE,	FREN	TUCK	- M	10-20	702	•
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay February 4, **Physician** Joseph Edward Kureth, Jr. 2009 11:44 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F 219-44-5225 62 May 4, 1946 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2900 Uniontown Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disc Jockey Radio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph E. Kureth, Sr. Margaret Owens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kureth, wife 2900 Uniontown Road, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of Segnetary, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 🗀 Removal from State 2/6/2009 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Wēstminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, all ock. In heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1∐Yes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

that the death certificate be executed 68760 Box P.0. Records, Vital o Division

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, I'm Medical Examiner must be notified at

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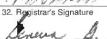
Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 05301Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Year **Physician** 4b. City, Town, or Location of Deeth 1030 Joseph Kelliebrew /Medical c. County of Death 4a Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, 3504 BASUN StatiON Prince George's Road if Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 1⊠M 2□ F 89 579-16-0765 Yrs 09/09/1919 Director Elizabeth City, NC Usual Residence of Decedent death with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Md. Prince George's Funeral Director Upper Marlboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 Brown Station Road 20772 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status i filed within 72 hours after de I Hygiene. other then "natural", or item 1X Yes 2 No If Yes, Give 1 1 ☐ Never Married 2 ☑ Married Black altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify '43-'46 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Marntenance Supervisor Elementary/Secondary (0-12) 12th College (1-4or 5+) U.S. Government Bureau of Census other 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be William Kelliebrew Odie Spruill 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Kelliebrew/Son 2211 Evarts St., N.E., Washington, D.C. 20018
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 02/13/09 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co. 21. Signature of Funeral Service Licensee ,Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Ent. the disease, if complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · AThersoleratic Cardinascular Heart Disease Examiner Examiner the attending physician end ched for use es the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of deeth? s been signed by the should be detech 1 ☐ Yee 2 ☐ No 3 ☐ Probably ✔☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending deeth. 2 □ No investigation 1 ☐ Yes Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide efter within 24 hours e 29a. Certifier Medical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ 31. Date filed (Month, Day, Year) State Registrar

05302

Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydrol Exprining rust be nutlined at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

6 State Registrar

1 - State Registrar	Cer	tificate of L	Death		R	eg. No.	707	0 0 0 0 2		
1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of Death		
MITCHELLO KABIA	1				Month FEBRUA	RY 3	2009	5:40 P M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o	of Death		4c. Count	y of Death			
HOLY CROSS HOSPITAL		SILVER	SPRIN	IG		MONTO	GOMERY			
5. Social Security Number 6. Sex 7. Age (In yrs. le	* 1	If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Count	ace (State or Foreign		
230-91-3732 X M 2 F 52	Yrs.				DEC 24	1956	SIERR	Á LEONE		
Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Loc	eation					10	d. Inside City Limits		
								1 XYes 2 No		
MD MONTGOMERY 10e. Street and Number	SI	LVER SPR 10f. Zip Code	ING		1	10g. Citizen of What Country?				
		209	04		USA	TTTAL OCUIT	.,,.			
# 7 CARTERS GROVE COURT 11. Marital Status 12. Was Decedent Ever in U.S.	s. 13. V			cifv Yes or No-		ice - America	an Indian.			
Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No		Vas Decedent of Hi f Yes, specify Cuba		Rican, etc.)		ack, White, e	tc.			
If Yes, Give Year or Dates:	1	∐Yes X∏No	Specify:			Speci	fy: BL	ACK		
15. Decedent's Education	16a. Deced	lent's Usual Occup	ation	A = 6		16b. Kind of E	Business/Ind	ustry		
(Specify only highest grade completed) Elementary/Secondary (0-12)	life. E	kind of work done of OO NOT use retired	luring most }	t ot workin	g					
4	COMI	PUTER TEC					PRIVATE			
17. Father's Name (First, Middle, Last)					(First, Middle, I		me)			
SANTIGIE KABIA			KA	DIJA'	TU KAM	ARA				
19a. Informant's Name/Relationship (Type. Print) REBECCA KABIA TOGBAR/WIFE		g Address <i>(Street a</i> ARTERS GR						Code) YLAND 20904		
06	lace of Dispos	sition (Name of natory or other plac	ا (م	Da	ate	20c. Location	- City or Tov	wn, State		
I TO BURIAL 2 L.I.Cremation 3 L.I.Hemoval from State 1		HEAVEN CE		2/14/	2009	SILVER	SPRIN	IG, MARYLANI		
21. Signature of Funeral Service Lieensee		RAL HOME								
the the	74	474 LANDO	VER R	ROAD	LANDOVE	R,MARY	LAND	20785		
23a. Part 1. Enter the disease, or complications that caused the death		Approximate Interval Between								
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conditions) NONSMALI		Onset and Death								
disease or condition resulting in death) Due to (or as a consequence)	-									
BONE METASTASES										
Sequentially list conditions, if any, leading to immediate but to (or as a consequence).										
cause. Enter Underlying Cause (Disease or injury that initiated events c. BRAIN ME										
resulting in death) Last Due to (or as a consequ										
d. HYPERTEN	NSION									
IF FEMALE:										
23b. Was decedent pregnant 23c. If yes, outcome of pregnant		Ectopic pregnancy	/				ate of delive			
1 Yes 2 No 4 Pregnant at time of de		Other (specify)	•			M	lonth	Day Year		
9 Li Onknown					00 5		4.75			
Part II. Other significant conditions contributing to death but not resu	liting in the ur	naerlying cause give	en in Part I.		1005			e cause of death?		
					1/2/	es 2∐No	3∐ Proba	ably 4 🗌 Unknown		
					24a. Was a			osy findings available opletion of cause of		
					perfori		death?	2 X No		
25. Was case referred to medical examiner?			26. Place	of Death	(Check only on					
1 Yes 2 No Hospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Othe	er: 4 □ Nu	ursing Hon	ne 5 ☐ Reside	ence 6 🗆 Ot	ther (Specify)		
27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injur	y at	2	8d. Describe ho	w injury occu	rred			
2 Accident investigation			Yes 2 □	No						
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hot building, etc. (Specify		eet, factory, office		2	8f. Location (Si City or Town		ber or Rural	Route Number,		
				14						
29a. Certifier (Check only 2 Medical Examiner: On the basis of examinat	wledge, death tion and/or in	n occurred at the tir	ne, date ar pinion, dea	nd place, a	and due to the ded at the time.	ause(s) and nate and place	nanner as st , and due to	ated. the cause(s)		
one) and manner stated.										
29b. Signature and title of certifier		29c. License			_	9d. Date sign	ea (Month, E	Jay, Year)		
Barbara Suparich, Br	n, a	D D C	065	485		02/	031	2-009		
30. Name and address of person who completed cause of death (Item			D CT	ת מונד ז	CDDING	MADVI A	NID 200	210		
BARBARA A. SUPANICH M.D. 1500 31. Date filed (Month, Day, Year) 32. Registrar's Signat		GLEN ROA	m STI	LVEK	SPKING,	MAKILA	אט און	710		
FEB 0 6 2009 Server 18.	AN									
	•//		_							

09-01298 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edward Keller, Sr. State of Maryland / Department of Health and Mental Hygiene 2009 05303 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day February 13, 2009 **Medical Examiner** Edward Keller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14510 Uhl Highway Cumberland Allegany 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD Months Hours Min Director Days 220-30-8079 1 X_M 2 F Oct 2, 1935 73 Usual Residence of Decedent 10c. City, Town or Location Cumberland any 10b. County MD Allegany or 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14510 Uhl Highway 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces?
Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married or **X**Widowed f Yes. Give Year Yes 2 XNo specify: Divorced Specify "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Itimore, MD 21215-0036

it. Pages I and 2 should be filed within 72 hortment of Health and Mental Hygiene.
Tanit: If item 27 is marked. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Float Department **PPG Industries** 18.Mother's Name (First, Middle, Maiden Surname) Hilda Squires Keller 17. Father's Name (First, Middle, Last)
John F. Keller, Sr. Be 19a. Informant's Name/Relationship (Type, Print)
Cynthia Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 12901 Lewis Heights Dr. LaVale MD 21502 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Itimore, or other Burial 2 Cremation 3 Removal from State crematory or other place) 2/17/20b9 Department of Important: 1 Flintstone Rocky Gap Veterans Cemetery Other Specify: Donation 5 ice Licensee 21. Signature of Funeral Ser 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Part I. Enter the disease or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on enth line. /Medical a Cirrhosis of the liver with complications Immediate Cause (Final disease or condition resulting in death) xaminer Due to (or as a consequence of) b Chronic Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed ian/Medical UNPENDED the attending physician ed for use as the burial AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month 2 past 12 months? Pregnant at time of death Physic Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? þ ۵. Yes 2 ✔ No 3 Probably 4 Atherosclerotic Cardiovascular Disease Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy performed? ✓ Yes 2 Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Hospital: DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending Yes 2 the Director: 2 Accident Investigation filled in by

prior to completion of cause of death? 2 1 1 Yes Residence 6 V Other: Scene 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 14, 2009 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day, Yea 32. Registrat s Signature

3. Time of Death

1415 hrs

10d. Inside City Limits

No

ΜD

Approximate Interva

Between Onset and

Death

Year

Unknown

No

1 XYes 2

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white

Day

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Funeral

within 2 To the 1

OCME

State Registra

cal

			A 57'.	partment of Health and Mental Hygiene Sertificate of Death Reg. No. 2009 05304
			Decedent's Name (First, Middle, Last)	Date of Death 3. Time of Death
	Physici /Medio		Mary W. Langdon	Month Day Year January 28 2009 00:43 AM
on back.	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			517 Deans Bank Road	North East Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min. (Month, Day, Year) Country)
	Director		218-26-6946 78 Vrsual Residence of Decedent	Nov. 29, 1930 New York
	yland Now		10a. State 10b. County 10c. City, Town o	Location 10d. Inside City Limits
	a-f st	ctor	Maryland Cecil North	Tast
	or 28	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	23a		517 Deans Bank Road	21901 United States
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evarines must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☒ XDivorced Year or Dates:	1 □Yes 2♥No Specify: Specify: White
2-003	hour stural	ed	1141	ecedent's Usual Occupation 16b. Kind of Business/Industry
215	ann 72 In "ne Media	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of working e. DO NOT use retired)
21	filed within Hygiene. other than "	ĕ		Naitress Restaurant
g	a g g	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
<u>yla</u>	should be and Mental s marked o umatic eve	2	James Williams	Elizabeth Harris
Maryland	l 2 sh h and r is m raum			ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e)	es 1 and 2 should b of Health and Ment Item 27 is marked r other traumatic e			B Essex Street, Churchton, Maryland 20733 sposition (Name of Date 20c, Location - City or Town, State
altimore,	Pages nent of int: If Its iry or o		1 Neurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	rematory or other place) February Ast Methodist 1.1 1.2 1.
	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Specify) C 21. Signature of Fineral Service Licensee	emetery 11, 2009 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home
ñ	Dep Imp			127 South Main Street, North East, Maryland21901
			23a. art 1. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	Physician		Shock, or heart failure. List only rine cause on each line.	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (o) a a consequence of):	unknown
	Examiner		Sequentially list conditions, b	
	pe şiş	Examiner	I if any localing to immediate Due to (or as a consequence of):	1
	xecut and I-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):	noshulan Ketoalidosi in
8/60	icate be executed physician and the burial-transit		but to for as a consequence on).	Porst-
	ificate g physis the	edical	d.	
ROX	death certific e attending p d for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
D.	deat deatte	sician/Me	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year
7. O	w requires that the de been signed by the should be detached	Phys	9 Unknown 9 Unknown	
	res th iigned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	
0	requires peen sign hould be	sted		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Kecords	6 0 C	Completed		24a. Was an autopsy findings available prior to completion of cause of
_	r: The ficate h r, page			performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
-	Physician: The law this certificate has tral ral director, page 2 s	Be	25. Was case referred to medical examiner? 1	26. Place of Death (Check only one)
0	y Phy er this eral d	7: To	27. Manner of Death 28a. Date of Injury 28b. Tim	4 Nursing Home 5 Hesidence 6 Other (Specify)
0	ath.	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injui 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No
DIVISION	er deg	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number,
5	ital or rrs aft ral Dir	Cer		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	ical	Construction Z Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the the small	Medical	one) and manner stated. 29b. Signature and tiple of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	F ≥ F 8	_		
	2		30. Name and address of person who completed cause of death (Item 23a) (Type	D0026183 2-6-09
			Madhu Sachder M.D. 322 E.	ecil Ave. North EAST md. 21901
	Sta		24 Date filed (Month Day York)	
	Registra	ar	FEB 0 9 2009 Service A. Aar	Ke/

09-Gv

01075 endolyn Lindo	1	1- For State Certificate of Death Reg. No.	2009 0530
Physicia dical Exami	ın/ ner	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 5, 2009	ear 3. Time of Death 1534 hrs
		727 South Camden Avenue Fruitland Wicom	iico
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YY) Months Days Hours Min. 3-20-58	Country)
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10g. Citizen of Number 10g. Citiz	10d. Inside City Limits 1
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies after them "natural", or items 23a or 28a-f sho ar 21 is marked other than "natural", or items 23a or 28a-f sho armotic event, the Medical Examiner must be notified at once.	Dire	727 South Landen H.V. 2/826 USZ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Ray	rce - American Indian, Black, hite, etc.
s after death ral", or iten	by Funeral	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No specify: Specify: Specify:	016
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examin	ied ied	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	onalds
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. If filen 21 is marked offer than 'injury or other traumatic event, the Medical.	Be (17. Father's Name (First, Middle, Last) 18. Motron's Name (First, Middle, Maiden Surnal 19. Informant's Name (Relationship (Type, Plint)) 19. Mailing Address (Street and Number or Rural Route Number, City or T	swh
imore, MD 2' Pages 1 and 2 should ment of Health and M lant: If item 27 is m or other traumatic e	To	The Pear Johnson 20b. Place of Disposition (Name of cemetery, Date 20c. Location	7, Nd 2/822 on - City or Town, State
Baltimore, permit. Pages I at Department of the Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee	V DE relait me
Physician Medical .aminer		23a. Part I. Enter the disease or complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one ause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated) b	Detween Onset and
executed an and al - transit		0.	
ox 68760, ath certificate be attending physici or use as the buri	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23a, 27, PETILE, goog 3/10/09 11 23d. Dat Month 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	e of delivery th Day Year
ires that the designed by the	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use c 1 Yes 2 No	ontribute to the cause of death? 3 Probably 4 Unknown
Records, The law requit cate has been s	omplete	24a. Was an autopsy performed? 1 ✓ Yes 2 No	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital Recing Physician: The l	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	6 🗸 Other: Scene
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Furnaria Director: After this certificate has been signed by	Certification:	27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury of 1 Yes 2 No 28d. Describe how injury of 28d. Describe how injury	umber or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Functral Direction for the	al Certif		inner as stated.
To the within 7 To the To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceath occurred at the time, bate and place, and manner stated. 29b. Signature and title of certifier 29d. Date	signed (Month, Day, Year) ry 6, 2009
		Therefore Me King Thomas . Name and address of person who completed cause of death (Ikim 23a)	

31. Date filed (MoFEP, Yaa') 2009 State Registrar

Theodore M. King, Jr., MD.

Assistant Medical Examiner

egistrar's Signature

111 Penn Street, Baltimore, MD 21201

		4	For State Registrar	Sta	te of	Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>					gien Reg. N	001	9	05306			
17			Decedent's Name (First, Midd	le, Last)								2. Date of De	ath			3. Time of Death			
	Physicia		Ruth	Eleano	r		T	ovett			-	Month Februar		, 2009	ear	8:42 A. M			
	/Medic Examin		4a. Facility Name (If not institution			nber)	.LA	4b. City, 1	Town, or	Location		COLGGE		c. County of		0012			
Đ)	EXAMILIA	eı	Southern M	arvland	ryland Hospital Clinto					on			P	rince	nce George's				
	Funeral		5. Social Security Number	6. Sex		_	rs. last birthday	If Under	1 Year	If Under		8. Date of Bir	th	9	Birthp	lace (State or Foreign			
ŀъ	Director		579-38-7341	1 □ M 2	¥F	77	Yrs.	Months	Days	Hours	Min.	04/29/1	931	" W	Coyin Iash	.,D.C.			
			Usual Residence of Decedent					1											
	yland Jow at		10a. State 10b. County	/		10c.	City, Town or L	ocation							1	0d. Inside City Limits			
	a-f sl	cto	D.C.				Wash:	ington	1							1 □Yes 2 □ No			
	or 28	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of Wha		itry?			
	th wit		5512 Foo	te St.,	N.E	•				200	119			U.S.					
	dea	Funeral	11. Marital Status	12. Wa	s Dece	dent Ever in	n U.S. 13.	Was Deced	lent of Hi	ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Black.	Americ White,				
9	after or ite	T.	1 ☐ Never Married 2 ☐ Ma	rried 1 [2 💢 No		1 ☐ Yes 2		Specify		, , , , ,		Specify:	_	ack			
93	ral";	å þ	3 ∰Widowed 4 ☐ Divorce	d Ye	ar or Da	ates:													
2-6	72 h natu dle a	etec	15. Decede (Specify only high	nt's Education est grade comp	oleted)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occup rk done d	ation during mo	st of work	ing	16b.	Kind of Busir	ness/Ind	dustry			
2	ithin nan t	g	Elementary/Secondary (0-12)	Co	llege (1	-4or 5+)		prieto		1)			Dr	y Clea	nin	α			
2	filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or items 23a or 28a-f show ant, the Medikal Examiner must be notified at	Completed	12th				FLO	oriec	<u> </u>	10 Mode	arla Nama	e (First, Middle				· · · · · · · · · · · · · · · · · · ·			
n	be fill tal H d ott	Be	17. Father's Name (First, Middle Edward Harri									Evans	, iviaide	en Surname)					
<u>X</u>	should be and Mental simarked oumatic eve	ပ္					1												
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relation Denise Chinn/D	_{ship (Type. Pri} Daughtei	int)							al Route Numb inton . N			ate, Zip 207	'			
2	and lealth m 27 her t					200	b. Place of Disp												
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Remova	State	cemetery, cre	matory or o	ther plac	ce)			20c. Location - City or Town, State Washington, D. C.							
Ξ	Pages ment of I ant: If ite		4 Donation 5 Other (~	M	t. Oliv			- 1		3/09	1		con,	D.C.			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee	3,	all	/ '	H.S. 4925 E	Masi Wasi Burro	ss of Faci ningt oughs	on & Ave	Sons C	o., Was	Inc. hingto	n,D	.C.20019			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between													Approximate			
	Physician		Immediate Cause (Final				l Tofen	+								Onset and Death			
	/Medical		disease or condition resulting in death)	u.	-		L Infard sequence of):	CLION							-				
$\tilde{}$	Examiner						Mellitus	•											
		e e	Sequentially list conditions,	b	Due to /	or as a num	sequence of):	•							- 1				
	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Δ	tri	al Fib	orillat	on											
,	exection and all trains	Exa	resulting in death) Last				sequence of):												
8760,	cate be executed physician and the burial-transit	g		d															
89	fficate g phy is the	edic																	
Вох	The law requires that the death certific the has been signed by the attending proge 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. lf	yes, out	come pf pre	gnancy	- ·						23d. Date	of delive	ery			
-	death afte	cia	in the past 12 months? 1 ☐ Yes 2 🔼 No	4[□Pregr	oirth 2 🗆 F nant at time		□Ectopic pr □ Other <i>(</i> sp		У				Mont	h	Day Year			
<u>О</u> .	the o	ıysi	9 Unknown	9[Unkn	own													
	that ned b		Part II. Other significant condi	tions contribut	ing to de	eath but not	resulting in the	underlying c	ause giv	en in Part	1.	23e. Did	tobacco	o use contrib	ute to tl	he cause of death?			
ds	uires I sigr	d by										1 🗆	Yes	2 No 3	☐ Prob	oably 4 ☐Unknown			
00	v req beer shou	Completed										24a. Was	s an	24b. We	ere auto	ppsy findings available			
Ř	has ge 2	dm			-							auto	opsy formed?	pri de	or to co ath?	mpletion of cause of			
_ 	icate icate r. pag											1□ Yes	2 🔀 1	No 1E	Yes	2□ No			
Ζï	Physician: The la r this certificate had ral director, page 2	Be	25. Was case referred to medic examiner?	Hospita	al:		A EDIO III		Oth	or:		th (Check only		. To:					
or	Phys this al dii	은	1 ☐ Yes 2 No 27. Manner of Death		1 🗆	Inpatient : of Injury	2 ER/Outpatie			401	lursing He	ome 5 Res				y)			
Ü.	After funer	ion	1 Natural 5 ☐ Pend	ling		th, Day Yea		M /	28c. Injui Wor 1 □	rk? Yes 2[200. Describe	11011111	july socurred					
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Division or Vital Records,	fer c lired n by	Certification:	4 ☐ Homicide dete	mined 20	build	ing, etc. (Sp	ecify)	treet, lactory	y, omoc			City or Te	own, Sta	ate)	0, 110,	arriodio redinaci,			
	Hospital 24 hours a Funeral	2	29a, Certifier 1 Certify	ing Physician	: To the	best of my	knowledge, de	th occurred	at the ti	me. date	and place	and due to the	e cause	(s) and man	neras s	stated.			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director After th completely filled in by the funeral	edical		al Examiner: (n the b		nination and/or												
	To the I within 2. To the I complet	Mec	29b. Signature and title of certification							se number			29d. [Date signed ((Month,	Day, Year)			
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Ų			20 Name and address of reserve	n who made	ed carr	se of death	(Item 23a) (Type						-	2/6/					
D			30. Name and address of person				— <i>U</i>	_	610)4 Ol	d Bra	anch Av	e.,	Temp1e	Hi.	lls,Md.2074			
	St	ate	31. Date filed (Month, Day, Yea				_												
	Regist		FEB 0 9 2009	Denn	امعه	A. ,	ignature												
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LLOYD RUTH Μ. 4c, County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) isbur Comico 1 8. Date of Birth (Month, Day, Year) FEB 17, 19 If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Days Hours Min Months 1 □ M 2 🕅 F DELAWARE FEB. 1943 65 222-26-3410 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No SUSSEX MILLVILLE DELAWARE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19967 USA 25 WHITES NECK ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HUDSON CATHERINE **EVERETT** W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HAROLD C. LLOYD JR./HUSBAND 25 WHITES NECK ROAD, MILLVILLE, DELAWARE 19967 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2/7/09 CREMATORY OF DELMARVA DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 MO(343 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OBSTRUCTIUR CHRONIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

certificate be executed

Box 68760

P.0.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Nedical Evantine must be notified at

filed withir Hygiene.

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma once.

Examiner attending physician and for use as the burial-trar cate has been signed by the page 2 should be detached certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to Certification: To

Physician/Medical 2 Completed Be

IF FEMALE:

autopsy performed 1∐Yes 2⊞No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Hospital: 28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPECIZ 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 ☐ Pending investigation

25. Was case referred to medical examiner?

1 Yes 2 →No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

20058410

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

0 BOX 1733 SAWBUY ND 21802 HOSPICA

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SANAI **Physician** Month LUCAS 02 2009 08:50 A M 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROCKVILLE, WITT 1 - ...

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

A 2 02 2009 SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔭 F NONE Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at GAITHERS BURG, 1 Kres 2 No Director MONTGOMERY MARYLAND 10e. Street and Number 10g. Citizen of What Country? 20817 HVENUE #302 W. DIAMOND USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 T No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFAN1 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HNTONIO MARCELLUS [ANISHA HNDREA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 443 W. DIAMOND AVEUE, GAITHERSBURG, MARYLAND MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State STERL CYCLE 03 02 2009 HALL RIVER, NC 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Cic nsee 22. Name and Address of Facility SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PREMATURIT **Physician** XTREME disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1∐ Yes 2 **Z**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Items 23a or 28a-f show

'natural", or

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 Odum, Mb 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 20 Registrar **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:20 P M FEBRUARY 2009 GLORIA EILLEEN MERRIMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖼 F 87 Aug 9 1921 213-16-1435 Brunswick, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Podical Examination must be notified at 1 X Yes 2 No Director MD Frederick Brunswick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1201 Maple Terrace Lane, Apt. 502 21716 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. after 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 2 3 ☑ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Housewife 12 should be filed with and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Alberta Russell Lewis Henry Cornelius ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If Item 27 Is any Injury or other trai P.O. Box 10003, Breckenridge, CO 80424 George Merriman, Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Hagerstown Crematory 2/3/09 Hagerstown, MD 4 Domation 5 DOther (Specify) Barbara A. Williams, Owner 22. Name and Address of Facility
John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis robuble **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Infarction Examiner my cardial robable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Probable hI bleed. Due to (or as a consequence of): Box 68760, certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 No 1 □ Yes Physician: funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17750 challegange Bianch 02/03/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 400 W. 7th Street, Frederick, MD Bianca Udugampola,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrer's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09:45 AM **Physician** JANE February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster

der 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 212 F Director 220-26-5380 80 Sept 20 1928 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventina must be nutfited at 1 ⊠Yes 2 □ No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 102 Timber Ridge Drive Apt #123 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 The If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Mary Alice McClelland John William Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health an Important: if Item 27 is any Injury or other trau 356 Barnhart Road Westminster, MD 21158 Mary Ellen Henry/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Carroll Cremation, Inc 2/4/2009 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Printer AFunefally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION ACUTE Physician /Medical Due to (or as a consequence of): Examiner SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy for Month Year 5 Other (specify) i signed by the aid be detached for 2 No o 9 Unknown ۳. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the 6 ☐Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0017695 WIL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 ABDALLAH J. HELOU, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 Registrar

DHMH 17 Rev 1/2001

09-01003	
Harry McLaughlin, J	Jr.

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State of Maryland /	Department of He	alth and Me	ntal Hygiene

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	1- For State Registrar	Certific	ate of Death	Reg. No.	0
Physician/ Medical Examine	HARRY McLa	ughlin Je.		Date of Death Month Day Year February 3, 2009	3. Time of Death 0825 hrs
Çi.	4a. Facility Name (if not institution, give 7307 Rotunda Court	street and number)	4b. City, Town, or Location of Death Clinton	4c. County of D	
Funeral Director	5. Social Security Number 240-68-9172 Usual Residence of Decedent	M 2 F	hday) If Under 1 Year I If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9 04-29-1947	Birthplace (State or Foreign Country)
Maryland 28a-f show any datonce.	10a. State 10b. County	wrges CLIN			10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	10e. Street and Number 7301 ROTUNDA	COURT	10f. Zip Code 20735	10g. Citizen of What	•
	3 Vildowed 4 Divolced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R Yes 2 No specify:	can, etc.) White, et	merican Indian, Black, cc. 3 UACK
and 2 should be filed within 72 hours after and 2 should be filed within 72 hours after teath and Mental Hygiene. Team 27 is marked other than "natural", traumatic event, the Medical Examiner. To Be Completed by 1		ly highest grade completed) College (1-4 or 5+) 2+	Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retired HILITARY	1)	nment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	HARRY McLauGH		Queen	Esther Hcb	
e, MD 2121 I and 2 should be f Health and Mental item 27 is marked r traumatic event.	ANNIE NASIR / 3	SISTER 5	o. Mailing Address (Street and Number or Ru 715 Mehavry Dewe	Fayetkuille, No	28311
nore	20a. Method of Disposition 1	Removal from State cremat	ory or other place)	Date 20c. Location - Cit 5peing L	y or Town, State AKE, NC
Baltir permit B Departme Importan injury or	21. Signature of Funeral Service Licen			urst NW WA	SH OC 20011
Physician /Medical Examiner	failure. List only one cause on ea	^{ch line.} <u>Hypertensive</u> car	ot enter the mode of dying, such as cardiac or r Hiovascular disease	espiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
C)	Sequentially list conditions, b.	Oue to (or as a consequence of): Oue to (or as a consequence of):			
ted Insit	cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a consequence of):			
760, freate be executed gphysician and the burial - transit		AMENDED 23a,27,per	ME, g889 3/10/09 TT		
lox 68 eath certil eath certil eattending for use as	The state of the s	23c. If yes, outcome of pregnancy Live birth Pregnant at time of death Unknown		23d. Date of del Month	ivery Day Year
, P.O. Erres that the designed by the be detached do by Phy		contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribut 1 Yes 2 No 3	e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. rate of a vitending Physician: The law requires that the rape cleath Is all Pirector: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P				autopsy prior performed? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical	ospital:	26.Place of Death (Check on Other) Nursing		
n of Vi	1 Yes 2 No	28a. Date of Injury 28b.	atpatient 0 Bon 4 Harsing	Home 5 Residence 6 🗸 0 8d. Describe how injury occurred	Other: Scene
lon (leading) eath or: Al	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	1 Yes 2 No		
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the funeral edical Certification:	3 Suicide 6 Could not I	28e. Place of Injury - At home, fa	arm, street, factory, office building, etc. 2	8f. Location (Street and Number of or Town, State)	r Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled			ath occurred at the time, date and place, and di nvestigation, in my opinion, death occurred at t	' '	
	29b. Signature and title of certifier	2)	29c. License number O.C.M.E.	29d. Date signed February 4, 2	
R	30. Name and address of person who of Russell Alexander MD.	ompleted cause of death (Item 23a) Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201	-
State	31. Date filed (Month, Day, Year)	32. Registar's Signature			
Registra	FEB 1 7 2009 FE	- 10. M.		OGNIE	

Examiner Physician: The law requires that the death certificate be executed Box 68760. P.0.

attending physician and for use as the burial-trar after death.

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nacional Examiner must be notified at

permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Baltimore, Maryland 21215-0036

Division of Vital Records, the Hospital or Attending within 24 hours a

State Registrar

Medical

Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) STEINFELD

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the cause of th

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FEBRUARY

BARTIMORE

2000 32. Registrar's 31. Date filed (Month, Day,

and manner stated.

21223

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ate of Maryland / Department of Health a Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Azel Brugh Meadows February 4 2009 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**№** M 2□F Days Hours 92 236-24-0745 07/02/1916 Director West Virginia Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If Iten 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event; the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1109 S. Schumaker Dr., Apt. 312 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify. white 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ pharmacist pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harrison Meadows Annie Bertie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. John O. Meadows/son 3940 Devonshire Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or Salisbury Crematory 4 □ Donation 5 □ Other (Specify) 2/5/09 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 34 501 Snow Hill Rd., Salisbury, MD 21804 Gampson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year signed by the at d be detached for 5 Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>^</u> 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has by page 2 s autopsy perform certificate 20 No Yes Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 P ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Easternshore Dr Salisbury MD 21804 Mahesha Thimmarayappa M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State Registrar

DHMH 17 Rev 1/2001

Certificate of Death

2. Date of Death Month

February 13,

Year

United States

14. Bace - American Indian Black, White, etc.

White

Specify:

0252

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🕅 No

Maryland

2009

Ceci1

and manner stated.

32. Registrar's Signature

Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Dorothy Elliott MacKenzie

1. Decedent's Name (First, Middle, Last)

Physician

/Medical

Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 21921 20c. Location - City or Town, State Fair Hill, MD 21921 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 100 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Dother} \) (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

Hospital 24 hours a

Medical

State

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Catherine Lorraine Neel 2009 1:25p February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2050 Long Corner Road Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 220-36-6854 29,1916 Maryland Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the involved Examinating at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Mt. Airy Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic events." 2050 Long Corner Road 21771 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 KINo Specify ≥ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing/Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Joseph Thomas Neel Laura Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 South Main Street, Mt. Airy, Maryland 21771 Pat Schmidt/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 12/4/2009 Mt. Airy, Maryland 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtorm Home P. A. Pike, Frederick, Maryland 21702 <u>1 Opossumtown</u> 23a. P. r.1. Enter the disease or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each the. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** nonths disease or condition resulting in death) THEMOCANGINO WA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi Exami that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy for Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 No Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\square\) Nursing Home 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) After this funeral (28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 2 ☐ Accident 5 ☐ Pending investigation s after death. death. 1 ☐ Yes 2 ☐ No completely filled in by the t 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S 30. Name and address of person who completed cause of gleath (Item 23a) (Type, Print) 15 West 7th Street, Alan Rohrer MD Frederick, Maryland 21701 Day. EB (31. Date filed (Month, 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BERT NEWCOMB 455 0 30 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HNChorales. Wilcomico Center SALSBURY NURSING If Under 1 Year II Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□ F 166-12-8728 88 Director 08/24/1920 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exercises must be notified at Maryland 1 Yes 2 No Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Elberta Ave. 21801 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 [XYes 2 □ No If Yes, Give Army Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 al Hygiene. d other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Modern Cleaners manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Mental F Albert Augustus Newcomb. Sr. Marion Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is eny Injury or other trau once. 9 515 Elberta Ave., Salisbury, MD 21801 Betty Jo Newcomb/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/3/09 Salisbury, MD 21. Signature of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1 arrich Mongon CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CVA 4 WELK /Medical Due to (or as a consequence of): Examiner Syens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Examiner Due to (or as a consequence of) the ettending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificete 1□ Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide September of titled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DRUSHANATESAN. January 301 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISION 57 SALISBURY egistrar's Signatur 31. Date liled (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.O. I

Records,

Division of Vital

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State		State	of Maryla	nd / Dep	artmer <i>rtifica</i> :	nt of H	lealth Death	and M	lental H	ygier Reg. N	-	109	0 5	5317
			Registrar 1. Decedent's Nam	e (First, Middle,	Last)			, imou				2. Date of D	eath	-		3. Time	of Death
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	Funeral Director		5. Social Security N 081-07-		. Sex 1□M 2√F		2 Yrs.	Months		Hours	Min.	8. Date of E (Month, I 5 – 1 3	-19	16	NEW	YOR	K
	and *		Usual Residence of	f Decedent 10b. County		10c. C	City, Town or Lo	cation							1	Od. Inside	City Limits
	/laryla f sho	o	MD.	CHAF	RLES	100.	, , , , , , , , , , , , , , , , , , ,		ALDO	ORF							es 21 No
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2	tems tems	Funeral	11. Marital Status		Armed F	cedent Ever in l	J.S. 13.	Was Dece If Yes, spe	edent of H	lispanic Oi an, Mexica	rigin? (Sp ın, Puerto	ecify Yes or N Rican, etc.)	10-	14. Rad Bla	ce - Americ ck, White,	an Indian etc.	
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F- 6	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is resident Examination in any one.	To Be		7. Father's Name (First, Middle, Last) WILLIAM ERNST 18. Mother's Name (First, Middle, Maiden Surname) FLORENCE HUGHES													
Z/ Mary	shoul and M s marl	ř	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Maili	ng Addres	s (Street	and Numb	er or Run	al Route Num	ber, City	y or Town	, State, Zip	Code)	
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	/Medical Examiner		resulting in death)	-	Due to	o (or as a conse	1 2 2 2		Las		DICO	200				51	الميمضون
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> =	Physician: this certific		examiner? 1 ☐ Yes 2 [[Inpatient 2				4 ⊔ N	lursing Ho	me 5 🗆 Re	sidence	6 □Otl	her (Specia	(y)	
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Div	al or / s after il Dire	Certification: To	4 🗌 Homicide	determin	eu buil	ding, etc. (Spec	cify)					City or T	òwn, Sta	ate)			,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the	he best of my ki basis of examinancer stated.	nowledge, dea nation and/or i	th occurre	d at the ti	me, date a opinion, de	and place, eath occur	and due to the time	ne cause e, date a	e(s) and mand place,	nanner as s and due te	stated. the caus	e(s)
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			30. Name and add	ress of person w	ho completed ca	use of death (Ite	em 23a) (Type	Print))	(/An	e , 1/	Maiol	lon	60	MAK	7	2509
	- Cha	to	31. Date filed (Mor	nth, Dav. Year)	- FIAIN	Registrar's Sign	nature 2	YUL E		- pp	V	ا بر بادار	w 0		100	, .	
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 Month Day 2009 2:50 a February

1. Decedent's Name (First, Middle, Last) **Physician** Heather Michele Parlier /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital Cecil Elkton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F 216-98-3565 29 MD Director April 28, 1979 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 ▼No Director MD Cecil Elkton 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 1234 Old Field Point Rd. 21921 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 5 21215-0036 Specify: Specify 2 3 ☐ Widowed 4 ☑ Divorced White 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dermit. Pages 1 and 2 should be filed with Dupartment of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other trainmant. 12 Administrative Assistant Medical 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 Bruce A. Parlier Valorie A. Watts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valorie A. Buchholz/Mother 2216 Misskelly Dr., Raleigh, NC 27612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. February 9, 2009 West Chester, PA Signature of Juneral Service Licensee 22. Name and Address of Facility 4 Andrew G. Gee Funeral Home, 259 E. Main St.. Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exam burial-trar and exect Due to (or as a consequence of) P.O. Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Day Year 5 ☐ Other (specify) the 9□Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 2 Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature a d/title of certifier

to y

State Registrar 31. Date filed (Month, Day, Year) FEB 0 9 2009

Dimor

32. Registrar's Signature

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Wallace Irwin Pink 2:50 p.M February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Mallard Bay Care Center Cambridge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year June 24, 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 □ F 216-14-9674 84 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at Dorchester Cambridge Y Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 2616 Shane Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWI] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2K Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2X No Specify: white Specify: WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) wire cloth mfq. sales 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doris Bradshaw Irwin F. Pink ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. wife 2616 Shane Circle, Cambridge, MD 21613 Ann F. Pink 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/6/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 □Yes 2 □ No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cancer, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 st 24a. Was an autopsy performed? 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of eath 28b Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident thours after death.

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ely filled in by the fi 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type Print) Bramble Cambridge MD 0 100 hnson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			Registrar		Ce	rtificate of	Death	F	03320					
		М	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	nth Day Year	3. Time of Death				
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	Examin	-	4a. Facility Name (If not institution, give s	street and number)			or Location of Death		4c. County of Death	1				
7		4.	Golden Living Ce	enter		Cum	berland		Allegan	y				
Fig.	Funeral	10-	5. Social Security Number 6. Sex	,	yrs. last birthday	Months Days		8. Date of Birth	9. Birth	place (State or Foreign				
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	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cor	-				
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	r deg	Funeral	Tr. Marian Ciarao	12. Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
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a) O	the the		20a. Method of Disposition	2	0b. Place of Disp	osition (Name of		Date	20c. Location - City or	Town, State				
و	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	,		ematory or other parents of the pare		2/16/2009	Cumber	erland MD				
Baitimore,	artme		4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licens	1 0		is Memorial Cemetery 2/16/2009 Cumberland 22. Name and Address of Facility Scarpelli Funeral Home, PA								
g	permit. Page Department of Important: If any Injury or once.)//////////////////////////////////////		1				land, MD 21502					
			23a. Part . Enter the disease, or compli	ications that caused the	death. Do not e					Approximate				
			23a. Part . Enjer the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final							Interval Between Onset and Death				
	Physician /Medical		disease or condition resulting in death)			vagu	lan al	eiller	-t-	6 clays				
50	Examiner			Due to (or as a co	nsequence or):									
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):									
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
,	exect n and al-tra	Exa	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):									
09/89	certificate be executed iding physician and ise as the burial-transit			4										
8	ficate g phy ts the	/Medical												
X		/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p					23d. Date of del	of delivery				
ň	death atten	icia	in the past 1/2 months? 1 □ Yes 2 No	1□Live birth 2□ 4□Pregnant at time		☐Ectopic pregnar ☐ Other (specify)			Month	Day Year				
oj.	the or	Physicia	9 ☐ Unknown	9□Unknown										
7	The law requires that the death tte has been signed by the atter hage 2 should be detached for L		Part II. Other significant conditions con				given in Part I.	23e. Did to	obacco use contribute to	the cause of death?				
Vital Records,	luires n sign	d by	Rene	il dys	fruction	· .		1 🗆 '	Yes 2 No 3 □ Pr	obably 4 □Unknown				
Ö	w rec beel shou	Completed		0 0)			24a. Was	an 24h Were au	topsy findings available				
Ř	The last	E D	···					autor	prior to or death?	completion of cause of				
g	10 5		OF Mon ages referred to medical					1□ Yes	2 100 1 ☐ Yes	2 □ No				
5	slcian: certifica rector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 1	Hospital:	0EED/0 / "		26. Place of Dea							
Ö	Phys rthis raldii	. To	27. Manner of Death	28a. Date of Injury	2 ER/Outpati	ent 3 DOA	4 Lawrursing H		dence 6 Other (Spe	cify)				
	ding Ph h. After th funeral	ioi	1 Natural 5 Pending	(Month, Day Ye	ear) Injury	W	ork? □Yes 2□No	Lou. Describe	tow injury occurred					
Š	deatl ctor: / the	ical	3 Suicide 6 Could not be	28e. Place of injury -	At home farm			28f Location (Street and Number or Ri	ıral Route Number				
Division	l or Attencafter death Director:	Certification:	4 ☐ Homicide determined	building, etc. (S	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Location (Street and Number or Rural Route Number, City or Town, State)					
	spita ours neral		29a. Certifier 1 Certifying Phy	sician: To the best of m	time, date and place	, and due to the	cause(s) and manner as	s stated.						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examione)	iner: On the basis of exa and manner stated.	amination and/or	investigation, in m	y opinion, death occu	irred at the time,	date and place, and due	e to the cause(s)				
	Vithin ompl	Me	29b. Signature and title of certifier	/	^	29c. Lice	nse number		29d. Date signed (Mont	h, Day, Year)				
	->-0		Veter XIII	uca o	MD	0	0 4981		Februar	12.2009				
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	e. Print)	- //0 /		1	12,2009				
				2 HALL		2000 Ca	ving to	(C+. (Ly wheelas	nd Ad				
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		£ = 4	0							
				SERVE STATE	4	1201 15 5								

Certificate of Death

12:15 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

YONTHS.

Year

Day

1 ☐ Yes 2 X No

State Registrar

31. Date filed (Month Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

DACY LAMONT Smith
09-01027 Please

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

JNK UNK	1- For State	Certificate of Death	and Mental Hy	glerie Reg.	No. 200	9 0532
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) DARYL LAMONT SMITT	н	5 34 X	2. Date of Death Month D February 4,		3. Time of Death 0239 hrs
Wedical Examiner	4a. Facility Name (if not institution, give street and number)		, or Location of Death	rebruary 4, a	4c. County of Death	
. <i>F</i>	Joppa Road & Pershing Avenue	Parkville			Baltimore Cour	
Funeral Director	213-80-4673 1XM 2F	(In yrs. last birthday) If Under 1 Months I	Year If Under 24Hrs. Days Hours Min.	8. Date of Birth(I	MM/DD/YYYY) 9. Birth Foreign Cour	
any	Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town or Location				10d. Inside City Limits
<u> </u>	MARYLAND HARFORD		STREET			1 Yes 2 XNo
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	10f. Zip Coo		10g.	Citizen of What Count	
with the is 23a cenotif	1505 BLUE HOUSE COURT 11. Marital Status 12. Was Decedent E	Ever in U.S. 13. Was Decedent o	21154 f Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	
or items 23 : must be no		X No	uban, Mexican, Puerto I	Rican, etc.)	White, etc.	
ural",	3 Widowed 4 Divorced of Divorced or Dates: 15. Decedent's Education (Specify only highest grade comp	1 Yes 2 X		ork done 1	Specify: BL	ACK dustry
5-0036 led within 72 hours at tygene. other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4 or 5-	during most of working	life. DO NOT use retire		to "set	
0036 within giene. her tha Medic	12 17. Father's Name (First, Middle, Last)	DELIVERY	PERSON 18.Mother's Name	(First Middle Mai	FOOD DISTE	RIBUTION
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Niedreal Examiner must be notified at once To the Transmatic event, the Completed by Funeral Director	JOHN N. SMITH, SR.		AUDREY 1		dell'odifiante)	
, MD 2121 and 2 should be fil tealth and Mental E ten 27 is marked traumatic event,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (S				
re, MD s I and 2 sho of Health and If item 27 is ner traumati	AUDREY SMITH / MOTHER 20a. Method of Disposition	20b. Place of Disposition (Name of	NS PLACE, 1 of cemetery,		MARYLAND 20c. Location - City or	
nore	1 Burial 2 X Cremation 3 Removal from Stat 4 Donation 5 Other Specify:	crematory or other place) R.A. FERRIS & C	O. INC.	2/10/09	WEST CHEST	TER. PA
Baltimore, ME permit; Pages I and 2 s Department of Health at Important: If item 27 injury or other traum	21. Signature of Funeral Service Licensee	22 Name and Add				
Physician	23a. Part I. Enter the disease, or complications that caused the		WIS SUBFFU	HAVRE	DE CRACE I	Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries					Between Onset and Death
caminer	or condition resulting in death) Due to (or as a consec	quence of):				
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):		_ Ta-eX		
b. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial – transit Physician/Medical Examine	(Disease or injury that initiated events resulting in death) Last	quence of):				
60, rate be executed physician and reburial - transit Medical Ex.	d. UNPENDED AMENDED					
60, ate be e hysician e burial	IF FEMALE: 23c. If yes, outcom	e of pregnancy		2-4-4	23d. Date of delivery	
Sox 6876 death certificat te attending ph I for use as the ysician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	ncy	Month D	ay Year	
Box 687 e death certifice the attending p ed for use as th	1 Yes 2 No 9 Unknown g Unknown	other (Specify)				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Existence.		but not resulting in the underlying car	use given in Part I.		acco use contribute to to 2 No 3 Prob	he cause of death? ably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P				24a. Was an		opsy findings available
Vital Records, sysician: The law requirements of the certificate has been signification, page 2 should be Completed o Be Completed				autopsy perform 1 ✓ Yes 2	ed? death?	ompletion of cause of
tal Rections: The certificate rector, page	25. Was case referred to medical	26.F	Place of Death (Check of	only one)		
f Vit Physic or this or ral dire	1 V Yes 2 No Invariant 1 Inpatier		Other Nursin	g Home 5 Re 28d. Describe ho	esidence 6 Other	Scene
Division of 'Division of 'Spital or Attending Physicial or Attending Physicial Physici	1 Natural 5 Pending Feb 4, 2009				vehicle involved	in collision
ivision or Attuation de Directo lin by t	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, street, factory, off	fice building, etc.	or Town, Sta	te)	ral Route Number, City
Di ospital hours a y filled	4 Homicide determined (Specify) Maj	or Road / Highway			Pershing Avenue, Pa	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death occurred at the tim nination and/or investigation, in my op	ne, date and place, and inion, death occurred a	it the time, date ar	d place, and due to the	e cause(s)
To ron	29b. Signature and title of certifier		cense number		29d. Date signed (Mor	
	Fot (Moning - HS).C.M.E. 		February 4, 2009	· · · · · · · · · · · · · · · · · · ·
	30. Name and address of person who completed cause of de Patricia Aronica-Pollak MD. Assistant M		n Street, Baltimor	e, MD 21201		
State	31. Date filed (Month, Day, Year) 32. Registrar	's Signature				

			For State Registrar	State	of Marylar		artmen rtificate					giene Reg. No. 2 (009	050	323	
	Physicia	an	1. Decedent's Name (First, Middle Pamela Lee Stor								2. Date of Dea Month Februar	Dav	Year	3. Time of I		
	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City,	Town, or	Location	of Death			ty of Death	0.111		
£.		Ÿ.	6608 Scarlett	Lane			Fede		-			Dorc	heste	r		
	Funeral Director		5. Social Security Number 212-66-1210	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. 54	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Nov • 12	, 1954	9. Birthplace (State or Foreign Country) ,1954 Maryland			
	Du A		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside Cit	v Limits	
7	-f show ied at	tor	Maryland Dorch	ester	Ŧ	ederal	shurg							1 🗌 Yes	2 🔀 No	
7	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?		
2	23a o 1st be	a D	6608 Scarlett	Lane			21	632				USA				
	r dear	Funeral Directo	11. Marital Status	Armed F	edent Ever in U	l.S. 13.	Was Deced	lent of Hi lify Cuba	spanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ce - Americ ack, White,			
g .	s arte ", or if camin	by Fi	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Tyes If Yes, G Year or I	2∭XNo ive ⊃ates:		1 ☐ Yes	2 ⊠ No	Specify:	:		Spec	ify: Whi	te		
9500-612	z nour atural cal Ex		15. Decedent	16a. Dece	dent's Usua	l Occupa	ation		. I	16b. Kind of	Business/In	dustry				
בות בות	e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	_) (1-4or 5+)		kind of wor DO NOT us	rk done d se retired,	luring mos)	st of work	ing					
7	ygien yer th rt, the		12	1		Cash	ier	 -	10 14-15	ania Alama	e (First, Middle,	Retail		Store		
yland	ntal H ed oth	Be	17. Father's Name (First, Middle, Thomas William	*							th Agnes		ime)			
	mark matic	ဥ	19a. Informant's Name/Relations		ng Address	(Street a			al Route Numbe		n, State, Zip	Code)				
Ma	alth ar 27 is 27 is ir trau		Michael M. Stor	ne/Husban	d	6608	Scar	lett	Lane	e, Fe	ederalsh	urg, M	D 216	32		
e.	of Hear of Hear fitem rothe	29	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	2 □ Pamoval from	20b.	Place of Dispo cemetery, crei	sition (Nan	ne of ther plac	e) ;		Date	20c. Location	- City or To	wn, State		
Ĕ	ment ant: I	92	4 Donation 5 Other (S			matory o				2/8/2		Delmar				
Baltimore,	permit. Pages I and 2 should be blied within 12 hours after death with the Marylan permit. Pages I and 2 should be blied within 14 yiele. Important: I it liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Planeral Service	Liginse	ller	Z 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	^{2. Name an} eller 06 Ma	Addres Fun in S	s of Facili eral treet	Home Home t, Ea	e, P. O. ast New	Box 2 Market	07 , MD :	21631		
		4	23a. Port1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	ter the mod	e of dyin	-			rest,		Approximate Interval Betw Onset and D	veen	
	hysician	0.0	Immediate Cause (Final disease or condition resulting in death)	_a. I'le	testati	~ 01	Karl	an	(en	OL_				eatti	
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):										
	p #	iner	Sequentially list conditions, cause. Enter Underlying													
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):										
/60,	be ey sician buria	ical E			(0, 40 4 0000.	1401100 017.										
28	death certificate e attending physical for use as the															
ROX	ending use a	III/III	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf pregn birth 2 ☐ Fet	ancy	∃Ectopic pr	agnancy				23d. Date of delivery				
,	the deat	Physician/Med	in the past 12 nonths? 1 ☐ Yes ☐ No 9 ☐ Unknown		nant at time of		Other (sp						fonth	Day Year		
ras, r	w requires mat me deam cermicate been signed by the attending phys should be detached for use as the	þ	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying c	ause give	en in Part	l.	23e. Did to	obacco use co		he cause of de pably 4 □U		
ပ္	8 S C	Completed									24a. Was		. Were auto	psy findings a mpletion of ca	vailable	
Ĭ,	Ine Ite h	Com									perfo 1∐ Yes	noed? 2 □ No	death? 1 ∐ Yes	2 No		
V113	Pnysician: In this certificate al director, pag	Be (25. Was case referred to medical examiner?	Hospital:				Othe		e of Deat	h (Check only o	ne)				
0	this at dir	. To	1 ☐ Yes 2 ☐ No 27. Mariner o Death	28a. Date		ER/Outpatier 28b. Time o		'A	4 🗆 N	ursing Ho	ome 5 Resid	dence 6 0		fy)		
Sion	naing th. r: Afte e fune	tion	Natural 5 Pendin investig	g (Mo	nth, Day Year)	Injury	М	8c. Injury Work 1 □ '	k? Yes 2.⊑]No		,,				
DIVIS	al or Attendated after death	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inod Zoe. Flat	e of injury - At h ding, etc. <i>(Sp</i> ec	iome, farm, str fy)	reet, factory	, office			28f. Location (5 City or Tov	Street and Nun vn, State)	nber or Rura	al Route Numb	ber,	
	I o the hospital or Attending P. within 24 hours after death. To the Funeral Director: After i completely filled in by the funera	Medical C		ng Physiclan: To the Examiner: On the and ma)	
	To the P	Me	29b. Signature and title of certifie	551	101	MIN	290	License	number	~	76	29d. Date sign	ed (Month,	Day, Year)		
	10		30 Name and address of person	who completed car	ise of death (Ite	m/23a) (Type.	Print)	NO	76	d-	7.0	- 1	1/	/		
	Sta	to	31. Date filed (Month, Day, Year)	1, m) (c	Registrar's Sign	10501		DO 1	BOX	173	33,5	olish	MI) No	802	
	રાટ Registr		FEB 1	0 2009	Burns	A	back						/			

DHMH 17 Rev 1/2001

		_	For State Registrar	State of M	larylan				lealth a Death	and M	lental Hy	giene Reg. No.	200	9	05	324
			1. Decedent's Name (First, Middle, Last	")					··-		2. Date of De Month				3. Time o	of Death
	Physici /Medio		Luevenia Stra	auther							Feb.	5	2009	· ·	1: 4	0 a ^M
-	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, o	r Location of	of Death		4c.	County of [Death		
فمسد			Southern MD Ho				10.77	ntor		24 Hrs	8. Date of Bir		ince			S or Foreign
	Funeral Director		558-30-8831	M 2 ☐ F	ge (in yrs. i	last birthday) Yrs.	Months		Hours	Min.	4/24	192		a I i	forn	ia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10	d. Inside C	City Limits
	Maryl -f sho	ξ	TX Dallas		Copr	2011									1 □Yes	s 20 No
	r 28a	Director	10e. Street and Number		COP	Jerr	10f. Z	p Code				10g. Cit	izen of Wha	t Coun	try?	
	th with		105 Pecan Holl	WC			75	019				USA				
9	72 hours after death with the Maryland hatural", or items 23a or 28a-f show disal Examiner mest be motified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 Yes 2	?		If Yes, sp	ecify Cub	Hispanic Ori an, Mexicar Specify:	n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, V	Vhite, e	tc.	
5-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 □ Yes						Specify:			
15-0	ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, I're Modical Exami	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		16a. Dece (Give life.		ork done	durina mos	t of worki	ing	16b. K	ind of Busin	ess/Ind	ustry	
2121	d within giene. rr than "	E	Elementary/Secondary (0-12)	4	llege (1-4or 5+) Teacher								lic			
	should be filled wand Mental Hygies marked other taumatic event, It	Be C	17. Father's Name (First, Middle, Last)								(First, Middle					
Maryland	wuld b Ments arked artic e	P	John Williams								a Perl		•			
lar	2 sho and is me		19a. Informant's Name/Relationship (7								al Route Numb •				Code)	
	Health Health tem 27 i		Eloise Strauth	er Daug							toona		1 6 6 ocation - City		wn State	
0	Pages 1 nent of H ant: if ite ary or ot		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □	Removal from State	8 1	Place of Disponentery, cre										· • .
altimore,	+せせき.		4 Donation 5 Other (Specify)	Liı						/2009					
Bal	permi Depar impor any Ir once.		21. Signature of Funeral Service Licens	see		พิ้	1069	1ey	"Chav	71S	III F	uner	al S	erv rb	MD 1CE	2075/
	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	one cause on each	line. Vanud	h. Do not en		de of dyi	ing, such as				, arrive		Approxima Interval Be Onset and	ate etween d Death
	Examiner	Jer.	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	Λ	iratio	· pa	eumo	rie						-	unka	
8760,	cate be executed oblysician and the burial-transit	dical Examiner	that initiated events c											M9 K no	i way	
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Feta at time of c	al death 3	□ Ectopic □ Other (су				23d. Date of delivery Month Day			Year
ds, P.	v requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	underlying	cause gi	ven in Part	l,			use contribu ⊠No 3[
Division of Vital Records,	The law requate has been bage 2 should	Completed by									24a. Was auto perf 1 □ Yes		prio	r to cou	psy finding npletion of 2 XNo	s available cause of
ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?							e of Deat	h (Check only					
) V	physic this ce		1 ☐ Yes 2 📉 No			ER/Outpatie		JOA		lursing Ho	ome 5 ☐ Res			(Specif		
ion o	nding Plath. r: After t	ation:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		njury Day, Year)	28b. Time of Injury	of M	28c. Inju Wo 1 [ıryat ırk? ∐Yes 2.⊑]No	28d. Describe	how inju	ry occurred		Muss.	JALLE
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At h etc. <i>(Sp</i> ec <i>i</i>	ome, farm, st	treet, facto	ry, office			28f. Location City or To			or Rura	l Route Nu	ımber,
	e Hospit 24 hour 9 Funera letely fillk	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the be niner: On the basis and manner	of examina	owledge, dea ation and/or i	ath occurre investigati	ed at the ton, in my	time, date a opinion, de	and place eath occur	, and due to the red at the time	e cause(s	s) and mann d place, and	er as s d due to	tated. the cause	e(s)
Н	To the Forthin Forthin Somple	Me	29b. Signature and title of certifier	-/	,							29d. Da	9d. Date signed (Month, Day, Year)			
			Pointan Fara	hof	M.P.			De	7546	á			2.5.			
	4		30. Name and address of person who RoINTAN FAR 31. Date filed (Month, Day, Year)	completed cause o	f death (Iter	m 23a) (Type	Print)	orgia	Ave	List	+ 3-32	5.70	ing,	7 /	102	0902
	St	ate	31. Date filed (Month, Day, Year)	32 Regi	strar's Signa	ature &	arke									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:30 P M BARBARA_ FEBRUARY 10 2009 WRIGHT SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK
Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day,
Feb. 25, FREDERICK FREDERICK Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 70 Washington, D.C. Director 220**-**34**-**7839 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Modisal Evairing must he 21701 United States 9521 Bell Haven Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Higher Education Research Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Schifflect Andrew Nelson Wright မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2580 West El Camino Avenue, #13106, Sacramento, California 95833 Gary Smith / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pages Department o Important: If i any Injury or once. Smithsburg, Maryland Smithsburg Crematory 14, 2009 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Keeney and Basford PA Funeral Home
106 East Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Concer Immediate Cause (Final Uterine **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months' 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached for o 9 I Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performe 2 **11**0 certificate 1 ☐ Yes 2 ☑ No After this certification, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 JA 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records,

ospital or Attending Physician: hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the t

State Registrar

Medical

29b. Signature and title of certifier

29c. License number D0064624

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2/11/2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, Maryland 21701 MD Sandeep Sharma,

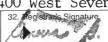
31. Date filed (Month, Day,

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only



and manner stated.

arka

Physician /Medical **Examiner**

Funeral

Director

28a-f show other traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Mexical Examinations.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760. Records, Division of Vital death.

To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely State

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 3 2009 Thompson 11:32 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Vindobona Nursing Home Braddock Heights | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEP 29 1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Months 1 □ M 2 🕱 F 217-32-7436 74 Sandy Hook, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Brunswick 1X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 USA 519 E. Potomac Street, Apt. 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. White <u>چ</u> Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Loudoun County Hospital Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Leesburg, VA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Robert Hughes, Sr. Hazel Camiell Powers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3380 Westport Drive, Jefferson, MD Claggett L. Thompson, Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory: 2/4/09 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
John T. Williams Funeral Home Juntale H 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL PAICURE ACUTE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 MNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOMY JOATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RHEUMATOIR ANTHRITLE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Brunswick, MA 21716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. GO NINTH 31. Date filed (Month. 32. Registra Gignature Deneus B. park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2–10–09Amend#18.PerFHPCCcr Certificate of Death Day 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year February C. County of Death 466 2009 oitawossen 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) May 2, 1953 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 156-92-5127 55 1 X M 2 D F Ethiopia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Director Md. Montgomery Silver Spring 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 20904 12369 Sandy Point Court U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Was Decedon. Armed Forces? 1 ☐ Yes 2 🛣 No Black White etc Yes, Gir 1 Never Married 2X Married 1 ☐ Yes 2 📉 No Specify: Black ş 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hydrogeologist Maryland State Gov't 5+ 17. Father's Name (First, Middle, Last) Tefera Tsertse-Dingel 18. Mother's Name (First, Middle, Maiden Surname) Be Engedawogh Beyene Engedawork Beyene ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 12369 Sandy Point Ct. Rebecca Abeya Silver Spring, Md. 20904 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 02/07 2009 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Md. Gate of Heaven Cemetery 4 Donation 5 Other (3) re f Fune I Service Lic 22. Name and Address of Facility W. H. Bacon Funeral Home, 3447 14th Street, N.W. Washington, DC 20010 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Inter the disease, or complication shock, or heard failure. List only one cau or complications that caused the death. e on each line Immer te Caus (Final 6 disease or condition resulting in death) Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

filed within 72 hours after death

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any injury or other traumatic event, once.

traumatic event,

Maryland 21215-0036

Baltimore.

The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division

Exami attending physician and I for use as the burial-trar Physician/Medical as Certification:

þ Completed Be ٩ 27. Manner of Death

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completely filled in by the funeral director,

State Registrar

DHMH 17 Rev 1/2001

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony Year)

and manner stated.

5 Pending investigation

6 Could not be

determined

28c

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Injury at Work?

1 Yes 2 No

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

29d. Date signed (Month, Day, Year)

5000

28d. Describe how injury occurred

2 ☐ Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier (check only

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

		-	For State Registrar	ate of Maryland / De <i>C</i>	Certificate of De		Reg. No.	2009	05328
	Dharaisis		1. Decedent's Name (First, Middle, Last)			2. Date o		Year	3. Time of Death
	Physicia /Medic		LUCY A. THOMPSON			FEBRU			3:36P ^M
	Examin	er	4a. Facility Name (If not institution, give street		4b. City, Town, or Le		4c. County of Death PRINCE GEORGES		
- 6	Funeral		SOUTHERN MARYLAND HO 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs. 8. Date o	f Birth	9. Birthp	lace (State or Foreign
	Director		300 22 6233 1□M	75 Yrs	Months Days	Hours Min. (Month	n, Day, Year) 05, 19	33 ALAI	
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits
	f shored at	ō		WASHI					YYes 2 No
	the N 28a- notifi	Director	DC 10e. Street and Number	WASHI	10f. Zip Code		10g. Citiz	zen of What Cour	itry?
	h with 23a or st be		1906 NAYLOR ROAD, SO	UTHEAST	20020		UN	ITED STA	TES
	ems a	Funeral	11. Marital Status	as Decedent Ever in U.S. 1	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Yes of Mexican, Puerto Rican, etc.	or No- 1	14. Race - Americ Black, White,	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1	∏Yes XXNo Yes, Give	1 □Yes XXNo	Specify:		Specify: BLA	
21215-0036	filed within 72 hours after death with the Maryland Hygene. Hygene they than "natural", or items 23a or 28a-f show off, I'm Marical Examiner must be notified at ent, I'm Marical Examiner must be notified at	ed b	3 ☐ Widowed ※ ☐ Divorced Ÿ 15. Decedent's Education	ear or Dates:	ecedent's Usual Occupati	ion	16b. Kir	nd of Business/Inc	
215	in 72 in "na Modic	Completed	(Specify only highest grade con	noleted) (G	Rive kind of work done du fe. DO NOT use retired)	ring most of working			
21,	d with	Com	Liementary/Secondary (0-12)		HIATRIC SOC			. GOVERN	MENT
nd	be file	Be	17. Father's Name (First, Middle, Last)		1	8. Mother's Name (First, Mi			
<u> </u>	should be filed within nd Mental Hygiene. marked other than matic event, in M	٩	ROSS T. THOMPSON 19a. Informant's Name/Relationship (Type. P	MARGARET MAR			Code		
Maryland	id 2 sl Ith an 27 is r traur		PEGGY T. BROWN / SIS			GTON, MD			
ē,	s 1 ar		20a. Method of Disposition	20b. Place of Di	isposition (Name of crematory or other place)			cation - City or To	
m	Page nent c int: If		XX Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	/ai from State		ERY 02/10/200	9 c	LINTON,	MD
Baltimore,	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 Is marked other thany injury or other traumatic event, it is once.		21. Synatur of Funeral Service Licensee	ALDRIGRAY	MARSHALL'S	FUNERAL HOME AND ROAD SUI	OF MA	RYLAND, MD 2074	INC.
			23a. Partil. Enter the disease, of complication should be called a complete the com	ns that caused the death. Do not	enter the mode of dying,	such as cardiac or respirate	ory arrest,		Approximate
1	Physician		Immediate Cause (Final disease or condition	metasta	Tue Ool	ios Osar Ca Liovoscula Lis	4	K	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	A' One	1: 11081 0.	N 80	210	~ 12
		er	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of):	ikie Cere	n	7 1000	as	mimous
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Diabela	& Mille	lis			in Known
oʻ	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequence of):		<u> </u>			
8760,	cate b	dical	d		-1				
Θ	eath certifi attending p for use as	(1)	IF FEMALE: 23c. If	yes, outcome of pregnancy				23d. Date of deliv	erv
Box	The law requires that the death certif are has been signed by the attending page 2 should be detached for use as	Physician/M	1 Ves WWNo	Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0.	uires that the de signed by the a d be detached f	hys	9 ☐ Unknown	Unknown					
	es tha igned be de	by F	Part II. Other significant conditions contribu	ting to death but not resulting in th	ne underlying cause given				ne cause of death?
ord	w requir been s should I	ted						□ No 3 □ Prol	
Vital Records,	e law has b	Completed					Was an autopsy performed?	24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
a	ician: The certificate h ector, page		25. Was case referred to medical			1 🗆 \	es 2 No	1 □Yes	2 No
Ξ	cia erti	Be	examiner? 1 Yes 2 No	tal: 1 Inpatient 2 ER/Outpa	Othor	26. Place of Death (Check of 4 ☐ Nursing Home 5 ☐		Other (Speci	fv)
ō	/si s c								
_	Phys this			Ba. Date of Injury 28b. Tim	ne of 28c. Injury	at 28d. Desc	ribe how injur	y occurred	
sion	ding Phys h. After this funeral dir		1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day, Year) 28b. Tim	ıry Work?	at 28d. Desc es 2 \(\subseteq No	ribe how injur	y occurred	,,
Division	ding Phys h. After this funeral dir		1		M 1 □ Y∈	es 2 No 28f. Locat		d Number or Run	
Division of	Hospital or Attending Phys 24 hours after death. Funeral Director: After this etely filled in by the funeral director.	Certification: To	1	(Month, Day, Year) Inju	M 1 □Ye	es 2 □ No 28f. Locat City c	ion (Street an or Town, State o the cause(s)	d Number or Run	al Route Number,
Division	Hospital or Attending Phys 24 hours after death. Funeral Director: After this etely filled in by the funeral director.		1	(Month, Day, Year) Inju Be. Place of Injury - At home, farm building, etc. (Specify) n: To the best of my knowledge, con the basis of examination and/and manner stated.	M 1 □Ye I, street, factory, office death occurred at the time or investigation, in my opi 29c. License	e, date and place, and due to inion, death occurred at the	ion (Street an or Town, State o the cause(s time, date and	d Number or Run and manner as a diplace, and due to the signed (Month,	al Route Number, stated. o the cause(s) Day, Year)
Division	l or Attending Phys after death. Director: After this I in by the funeral dir	Certification: To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 5 Pending investigation 6 Could not be determined 21 29a. Certifier (Check only one) 5 Pending investigation 6 Could not be determined 21 Medical Examiner:	(Month, Day, Year) Inju Be. Place of Injury - At home, farm building, etc. (Specify) n: To the best of my knowledge, con the basis of examination and/and manner stated.	M 1 □Ye I, street, factory, office death occurred at the time or investigation, in my opi 29c. License	e, date and place, and due to inion, death occurred at the	ion (Street an or Town, State o the cause(s time, date and	d Number or Run and manner as a diplace, and due to the signed (Month,	al Route Number, stated. o the cause(s) Day, Year)
Division	Hospital or Attending Phys 24 hours after death. Funeral Director: After this etely filled in by the funeral director.	Certification: To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of ceptifier	(Month, Day, Year) Inju Be. Place of Injury - At home, farm building, etc. (Specify) n: To the best of my knowledge, con the basis of examination and/and manner stated.	M 1 □Ye I, street, factory, office death occurred at the time or investigation, in my opi 29c. License	es 2 No 28f. Locat City of e, date and place, and due t inion, death occurred at the	ion (Street an or Town, State o the cause(s time, date and	d Number or Run and manner as a diplace, and due to the signed (Month,	al Route Number, stated. o the cause(s) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** A^{M} 4:33 James L. Thompson 2009 Feb. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 6 Sex **Funeral** Days Hours Min. 1 X M 2 □ F 264-14-7696 88 2, 1920 Florida Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Michael Event in a natural be notified at once. 10a. State 1 □Yes 2 No Director MD Prince Georges Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2709 Keating Street 20748 Α. Funeral 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify. Specify: þ Black 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Factory Worker Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Coursey James L. Thompson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2709 Keating Street, Temple Hills, MD 20748 Lorraine Huddleston - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2/11/2009 | Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 22. Name and Address of Facility Bell and Johnson Funeral Home, P. A. 21. Signature of Funeral Service Licensee ridit 6503 Old Branch Ave., Temple Hills, MD 20748 or inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. 23a. P. . . Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Physician Due to (r s a consequence of): /Medical Examiner Advanced Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and the attending physician Physician/Medical as the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown meumonia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide

Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ō

Baltimore, Maryland 21215-0036

hours after death uneral Director; within 24 hours To the Funeral

> State Registrar

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

RAHIMIAN, MD

and manner stated

Makeun ay MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0052999

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:45pm Vincent Ventola February -5 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Evergreen Independent Living Bowie Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1Q M 2□ F 79 2-15-1929 Director 140-22-7383 New Jersey Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director Bowie Prince Georges MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 4820 Riverton Lane United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Lojewski Vincent Ventola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sk Department of Health and Important: If item 27 Is n any Injury or other traun Janet Ventola Gagnon/daughter 12806 Chesney Lane Bowie MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2-10-2009 4 □ Donation 5 □ Other (Specify) Brentwood MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C' ar lit p w/mm

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): physician F FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🙀 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown fibrilletin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2K No 1∐ Yes 2K No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

72 hours after

Saltimore, Maryland 21215-0036

funeral director. this After

ig G	
ysician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 \(\overline{\text{Y}} \) 9 ☐ Unknown
Completed by Physicia	Part II. Other signifi
mplete	stril
o Be	25. Was case referrence examiner? 1 ☐ Yes 2 ☒ 1
ation: To	27. Manner of Death 1 And Natural 2 Accident

1 ☐ Yes 2X No

1 → Natural 2 → Accident

3 Suicide

29a. Certifier

4 Homicide

Certifica

Medical

The law requires that the denth certificate be executed the Hospital or Attending Physician: n 24 hours after death.

The Funeral Director: Af olderely filled in by the fun To the Hosp within 24 hor To the Fune completely fi

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury

(Month, Day Year)

Jute dol, Garbills MD 21054

Other: 4X Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of M State Amended #1 Per MD	/laryland FCHD, J	d / Depa V , 62/	rtment of F	lealth and M Death	Mental Hyg	eg. No.	09	05331
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Roger Alan Webb Roger A	lvin W	lebb			2. Date of Deat Month Februar	Dav	2009 Year	3. Time of Death 7:50 P M
A STATE OF THE PARTY OF THE PAR	Examin		4a. Facility Name (If not institution, give street and number 1844 Pleasant View Road	er)		4b. City, Town, or Adams t	Location of Death			nty of Death ederick	ς
	Funeral Director		5. Social Security Number 213–46–8648 6. Sex 7. / 1 ☒ M 2 ☐ F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8) Date of Birth (Month, Day, 02/21/	Year)	9. Birthpl Count Mary	ace (State or Foreign Tand
	ъ		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10	0d. Inside City Limits 1 ☐ Yes 2 1 No
	8a-fs	ecto	Maryland Frederick	Ad	lamstov			1	On Citizon	of What Count	
	a or 2	Dir	10e. Street and Number 1844 Pleasant View Road			10f. Zip Code 217	10	'		ed Stat	
	ns 23	nera	11 Marital Status 12. Was Deceder	nt Ever in U.	S. 13. \		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. F	Race - America	an Indian,
36	urs after o	by Funeral Director	Armed Force 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ If Yes, Give 3 □ Widowed 4 □ Divorced	∑ No		f Yes, specify Cuba 1 □ Yes 2 🖾 No	Specify:	Hican, etc.)		Black, White, e cify: Whit	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evertine, must be a wither at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	or 5+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	king		f Business/Ind	
212	d with giene er tha	Com	8 College (1-40	1 3+/	Painte	er/ Drywa	11 Instal		-		/Renovation
pul	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, Last) Stewart Ellis Webb, Sr.				18. Mother's Nam	_{le (First, Middle, I} rgaret R	_	ame)	
Maryland	d Mer narke natic	မ	19a. Informant's Name/Relationship (Type. Print)		19h Mailir	ng Address (Street	and Number or Ru			wn. State. Zip	Code)
Ma	nd 2 sillth an 27 is i		Patsy Ann Webb / Wife		1	-	View Rd.				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertired must be a chilled at once.		20a. Method of Disposition 1583Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ile	Kesti	sition (Name of matory or other place naven	Feb. 200	6,		on - City or To	_{wn, State} Iaryland
Baltir	permit. F Departm Importar any injur		21. Signature of In tal Service Licenson	I Men	Ŕ		Funeral	Services	, Skko	ot Cody	7 P.A.
San Property and the san Prope	Physician /Medical Examiner			n iirie.	h. Do not ent						Approximate Interval Between Onset and Death Months
68760,	icate be executed physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events c	as a consequal							
O. Box	death certifi e attending id for use as	Physician/Med		th 2☐ Feta nt at time of c	I death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d.	Date of delive Month	ery Day Year
ds, P.	w requires that the s been signed by th should be detache	þ	Part II. Other significant conditions contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
of Vital Records,	he law e has t	Completed						24a. Was a autop: perfor 1 □ Yes	sy	tb. Were autoprior to condeath?	psy findings available mpletion of cause of 2 No
/ital	ysician: T iis certificat director, pa	BeC	25. Was case referred to medical examiner?			Lou		ath (Check only or	10)		
of V	Physician: this certific ral director, I	မှ			ER/Outpatie	III 3 LI DOA I		lome 5 Resid			y)
Division	ding I. After fune	Certification:	1 X Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of	Day, Year)	Injury ome, farm, st	Wo	rk?]Yes 2□No	28f. Location (S	itreet and Nu		d Route Number,
Ö	s after s after al Dire	Certi	4 nornicide building	, etc. (Specii				City or Tow			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the buse and manne	is of examina	owledge, dea ation and/or i	th occurred at the to nvestigation, in my	ime, date and place opinion, death occi	urred at the time,	date and pla	ce, and due to	the cause(s)
	Voithii	M	29b. Signature and title of certifier	MA		29c. Licen	4818L			gned (Month, 4/89	
	9		30. Name and address of person who completed cause	of death (Iter	m 23a) (Type,	, , ,	the stre	et Fru	Lerich	(MD	21701
	St Regist	ate rar		gistrar's Signa	ature	Carthan B					

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** William Albert Welsh Feb 3 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice (Dove House) Westminster Carrol1 6. Sex 12€ M 2 ☐ F (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 2 (Mpnth/Plan 2 (mpnth/Plan 2 (mpnth/Plan 2 (mpnth/Plan 2 (mpnth)) **Funeral** Days Hours 219-18-1165 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, its "fedical Examinar must be notified at Funeral Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 Oakland Mills Rd. 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? PLAYes 2 \(\text{No} \) No 1943- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 21 4 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽNo Specify: White Completed by 1946 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) 10th College (1-4or 5+) Baltimore City Firefighter Firefighting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis A. Welsh Mary E. Grimes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Mayne (Daughter) 2348 Sandymount Rd Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem Park 2/6/2009 4 □ Donathon 5 □ Other (Specify) Sykesville, MD 22 Name and Address of Facility Burrier-Queen Funeral Home 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Licensee Physician /Medical Examiner Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

23a. Prt1. Enter the disease, or con shock, or leart failure. List only	inplications that cause the death. Do not enter the one cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. DEMEI	YTFA		Onset and Death
	Due to (or as a consequence of):	ACTA		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	0,31		
Cause (Disease or injury that initiated events resulting in death) Last	c. Attial Due to (or as a consequence of):	Fibrillat	707	
	ed. Debress	2100		
	a. — — — — — — — — — — — — — — — — — — —			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
			1 ☐ Yes	2 No 3 Probably 4 Upknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Deatl	(Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing Ho	me 5 Residence	6 Mather (Specify) DOVE
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	"'		28d. Describe how inj	
3 Suicide 6 Could not be determined		factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 ☐ Certifying P (Check only one) 1 ☐ Medical Exa	hysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)
29b. Signature and title of certifier	lowers MD	29c. License number D- 0 0 5 4 2	218 0	ate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈

05332

Ам

3. Time of Death

9:36

Birthplace (State or Foreign Country) MD

MD

10d. Inside City Limits

1 □ Yes 英語 No

DHMH 17 Rev 1/2001

WJL LTIVA

+2

State Registrar

Medical Certification: To

westminister

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Malcalm

31. Date filed (Month, Day, Year)

			1 – For State Registrar	State of M	larylan		artment of rtificate of		nd Mental Hyg	giene 200	9 05333
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Mary Aa. Facility Name (If not institution, 609 Wendellwoo	Ethel Wise			4b. City, Town, (or Location of I	2. Date of Dea Month Februar Death	Day Yea	9 3:00 a ^M
	Funeral Director				ge (<i>In yrs. l</i> e	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birth (Month, Day April 2	9. B	irthplace (State or Foreign Country) Ennsylvania
	vith the Maryland t or 28a-f show be notified at	Funeral Director	10e. Street and Number	ford	10c. City	, Town or Lo	Bel A			10g. Citizen of What 0	-
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinative must be notified at once.	þ	609 Wendellwoo 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 関Divorced	12. Was Decedent Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	7	1	Mas Decedent of I f Yes, specify Cub I □ Yes XXNo	Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Specify:	nerican Indian, ite, etc. White
-C1717 DI	e filed within 72 is al Hygiene. I other than "nat went, it a Model	Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) Eight Years 17. Father's Name (First, Middle, La	College (1-4or	5+)	(Give .	dent's Usual Occu, kind of work done DO NOT use retire Homema	during most of d) aker	f working Name (First, Middle, 1		Residence
, Mai yia	and 2 should be lealth and Ment n 27 is marked ner traumatice	To E	19a. Informant's Name/Relationship Stephanie Noye	ond Shenk M o (Type. Print) (Daughter)		609 We	endellwoo	od Driv		r, City or Town, State	Zip Code)
Jailling	permit. Pages 1 Department of H Important: If iter any Injury or ott		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Sign ture of Funeral Service Lie	cify)		enger 22	. Name and Addre	ery 0	2/09/09		Pennsylvania
	Physician /Medical Examiner	lical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a conseque	Do not enter	Perryvi	ng, such as ca	n & Son Fu aryland 2 rdiac or respiratory arr	1903-0766	Approximate Interval Between Onset and Death
	t the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	ey		23d. Date of d	elivery Day Year
, 55.00	w requires that sheet should be det	ρ	Part II. Other significant conditions	contributing to death b	out not resul	ting in the un	derlying cause giv	en in Part I.		es 2∭ANo 3∏ F	to the cause of death? Probably 4 Unknown
	iclan: The lar certificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?	Hospital:			Louis		Death (Check only on	prior to ned? death? 2 XINo 1 □ Ye	autopsy findings available completion of cause of
	To the nospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death 1) SNatural 2 Accident 3 Suicide 4 Homicide 2 Ackident Could not determine	28a. Date of Inju (Month, Da	ary (2 ay, Year)	R/Outpatient 28b. Time of Injury ne, farm, stre	28c. Injui Wor M 1 🗆	v at		ow injury occurred	
	the Hospiti thin 24 hours the Funera impletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex 29b. Signature and title of certifier	Physician: To the best aminer: On the basis o and manner sta	of examination	ledge, death on and/or inv	estigation, in my o	ppinion, death	occurred at the time, d	ate and place, and du	e to the cause(s)
)	.		S. Raguer		eath (Item:	23a) (Type, F		⊃537	20		C3 -
	Stat Registra	te	30. Name and address of person where the second of the sec	10 600 S	ar's Signatu	ire have	of Red,	#100	Beleei	i wo	21014_
	U 47 Day (122	004	TED V 3 4	www person	a p	· Man					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Cornell Aaron Woods, Sr. February 2009 10:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Director 249-52-7880 76 June 15, 1932 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Exa⊞lner must be notified at 1 XYes 2 No Maryland Prince George's Cheverly Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 2900 Mercy Lane 20785 <u>United</u> States death v Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Healith and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examinea ury or other traumatic event, the Medical Examinea. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Heating Plant Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erving Woods Daisey Player ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2100 Old Fort Hills Court Fort Washington, MD 20744 Aaron Cornell Woods, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cemt. Feb 12, 2009 Triangle, VA ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. of Funeral Sery 4001 Benning Road, NE Washington, DC 20019 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal Cardiac Arrhythmia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Urinary Tract Infection Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Pneumonia attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐ Yes 2☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Chronic Respiratory Failure 24a. Was an has e 2 autopsy perform certificate has 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this c funeral dire 1 😾 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064478 February 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Fisehatsion Mehari, M.D. 12700 Goodloes Promise Drive Bowie, MD 20720 31. Date filed (Month, Day, Year) FEB 0 6 2009 32 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05335 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 4, -^{Day}2009 4:37 P Margaret McKim Wolfe Lusby 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

July 3, 1924 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Maryland Months Days Hours Min. 1 □ M 2 □ F 84 577-26-4625 Usual Residence of Decedent 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2√√ No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14997 Health Center Drive #244 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White Specify: xX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 11th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earley Lusby Caroline McKim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. Wolfe—Elliot /Granddaughter 6909 Allentown Road Camp Springs, Maryland 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Feb. 7, 2009 Brentwood, Maryland 4 □ Donation 5 K Other (Specify Entombment 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Fundal ervice Lipenses olis 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 mop Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation

law requires that the death certificate be executed and P.O. Box 68760, of Vital Records, certificate Physician: After this

as the burial-transi attending physician for use as the burial nse signed by the a cate has page 2 s director funeral reral Director: A filled in by the fi

Physician

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.

Physician

Examiner

/Medical

3altimore, Maryland 21215-0036

/Medical

ospital or Attending I Division To the Hospital o within 24 hours aft To the Funeral Di completely filled in

6

State Registrar

31. Date filed (Month, Day, Year

FEB 0 6 2009

6 ☐ Could not be

determined

MO

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

21401

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anne Avandel

. Registrar's

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** REGIONAL MEDICAL SAUSBULL NICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min. Director 216-56-1144 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Health and Mental Hygjene. em 27 is marked other than "natural", or items 23a or 28a-f shov ither traumatic event, the Medical Examinar must be notified at 1 DYES 2 □ No Director Maryland comica 10e. Street and Number 10f. Zip Co 10g. Citizen of What Country? Inited Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Dever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2+4 aborer 2005tr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ +01504 ialah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Staw, Zip Code) rive omes 20b. Place of Disposition (Name o cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Jown, State 3 Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) envern 21. Signature of Funeral Service Licenses Funeral 821 West Mar Approximate Interval Between 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician vicz /Medical Due to (or as a consequence of): Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🗆 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

State

the

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29b. Signature and title of certifie

30. Name and address

400 E. Shore

29d. Date signed (Month, Day, Year)

2009

and manner stated

11.0. Registrar's Signatu

ed cause of death (Item 23a) (Type, Print)

Box 68760 P.O. Division of Vital Records, After

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 4a,4b,4c per phys. Good Framework of Maryland / Department of Health and Mental Hygiene

Certificate of Death 05337 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DONALD LESTER WADE 7:44P M FEBRUARY 8 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Anné Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours XXM 2□ F Director 578-42-5061 76 WASHINGTON, DO JAN.9,1933 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD CHARLES PORT TOBACCO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 COVENTRY COURT 20677 Funeral S. 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1∐Yes 2∏xNo β Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 SYSTEMS ADMINISTRATOR T_ is marked other or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any liny or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM LESTER WADE ARMENIA FRANCES WINDLE ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYRNA MEYER WADE/SPOUSE 6500 COVENTRY COURT PORT TOBACCO, MD 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 16, 2009 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL . SERVICE, P.A. 21. Signature of Funeral Service Lic M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mantle cell lyuphoma Immediate Cause (Final disease or condition resulting in death) **Physician** 4 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of if any learn to improve cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Lung cancer 1 Yes 2 No 3 Probably 4 Unknown Completed Cavalio my opath 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation reral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier include, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, Md. 21401 Selonicu, mo 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ares Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma		ertificate of E		Reg.	2009	05338
	Physici		Decedent's Name (First, Midd Arbutus	le, Last) Virginia	Waliz	er		2. Date of Death Month FEBRUARY	Day Year 14 2009	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or I			4c. County of Death	
أسامي				AL CAMPUS		CUMBERLA			ALLEGAN	ΙΥ
	Funeral Director		5. Social Security Number 215-64-4866 Usual Residence of Decedent	6. Sex 7. Age 1	e (In yrs. last birthda 85 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes Sep 4, 1	923 9. Birth	place (State or Foreign intry) MD
	Maryland a-f show	ctor	10a. State 10b. County	legany	10c. City, Town or	Location umberland				10d. Inside City Limits 1 □Xes 2 □ No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 300 East Elde	er Street		10f. Zip Code	21502	10g.	Citizen of What Cou USA	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examination is institled at once.	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Midowed 4 Divorced	If Yes, Give	Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 □ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
215-0	thin 72 ho ie. an "natur Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary_(0-12)	nt's Education est grade completed) College (1-4or 5	(Gi life	cedent's Usual Occupa ve kind of work done do DO NOT use retired)	uring most of workir	ng	. Kind of Business/li	ndustry
2	ygien ygien ier th	ខ្ល	12		Nu	rsing Assista			Hospital	
yland	should be filed and Mental Hygi s marked other numatic event,	To Be	17. Father's Name (First, Middle, John Willia	m Foreman			Anna	(First, Middle, Maid Mae Fore	eman	
, Mar	1 and 2 sho Health and em 27 Is mi		19a. Informant's Name/Relations Brenda Goetz	ship (Type. Print) Z dau	ughter 2	ailing Address (Street a 200 East Eld	ler Street	Cumb	erland	MD 21502
Baltimore, Maryland 21215-0036	Pages 1 a tment of He tant: If Item fury or oth		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (20b. Place of Dis cemetery, c Hillcrest I	position (Name of rematory or other place Memorial Park	D	2/18/2009	Cumberla Cumberla	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	/////	,		ginia Avenue	: Cumberland	I, MD 21502	
	Physician /Medical Examiner		23a. Part . Enter the disease . shock, or hear failure. Lis Immediate C / use (final disease or or ndition resulting in feath)	or respiratory arrest,	UL. DISPIS	Approximate Interval Between Onset and Death				
	eath certificate be executed attending phystcian and for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	a consequence of):					
89	ficate g phy s the	edical		u						
O. Box	ath cer attendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	quires that the de in signed by the a uld be detached f	þ	Part II. Other significant condit	ions contributing to death b	out not resulting in the	underlying cause give	n in Part I.			the cause of death?
Reco	The law require Ite has been sig age 2 should b	Completed						24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
<u>ta</u>	ian: artifica stor, p	Be C	25. Was case referred to medica examiner?	al			26. Place of Death			
>	hysic his ce I dire		1 Yes 2 No	Hospital: 1 ☑ Înpatie	ent 2 ☐ ER/Outpa	tient 3 DOA Othe	r: 4 🗆 Nursing Hor	me 5 🗀 Residence	e 6 ⊡Other (Spec	cify)
0	ng Pl fter ti meral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Inju	ury 28b. Time ay, Year) Injur			28d. Describe how i	njury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	2 Accident invest	inot be 28e. Place of Inj	ury - At home, farm, c. (Specify)		∕es 2 □No │	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
_	e Hospita 24 hours e Funeral letely filled	Medical C		ing Physician: To the best i Examiner: On the basis of and manner st	of examination and/o					
	To th within To th compl	Me	29b. Signature and title of certifi	er ev		29c. License	23371	29d.	Date signed (Monti FEB 15	n, Day, Year)
			30. Name and address of person	who completed cause of a	death (Item 23a) (Typ	ton Dr.	Cum	berland	d, ma	21502
	Sta Registi		31. Date filed (Month, Day, Year	32. Registr	rar's Signature	barked.				

SX

State of Maryland / Department of Health and Mental Hygiene 05339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2:40 PM Wharton Mary Jane -2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12904 First Street Rawlings Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Jul 20, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ 🙀 Months Min Days Hours 213-24-6813 Yrs 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madesal Express. MD Allegany Rawlings Director 1 □ ¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12904 First Street 21557 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

1s marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify 3 ☐Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Martin Maude Martin ပ 19a. Informant's Name/Relationship (Type. Print)

David Wharton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 5 Box 522 Keyser WV 26726 Keyser son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2/16/20d9 MD Cresaptown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Part Home, PA 21. Signature of Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a / art 1. Et er the / isease, of cor plifati ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure / Likit only ine is use on each line.

Immediate Cause Final disease of condition resulting in death)

a. Due to (or as a consequence of Approximate Interval Between Onset and Death Physician Due to (or as consequence of) 00+.2002 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 ☒ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 SETON DR ZAMAN, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2k

			1 - For State Registrar	State of Maryland	/ Department of Certificate of		ental Hygie Reg.	7009	05341
	Physici /Medic		1. Decedent's Name (First, Middle, Last Wylle Boy	illus	4		2. Date of Death Month	Day Zoog Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give 1620 GWYMS For	-11 - 11	4b. City, Town,	or Location of Death Thimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 247-54-2599 1 Usual Residence of Decedent		t birthday) If Under 1 Yea Months Days		8. Date of Birth Month, Day, Ye	9. Birthy 1936 South	place (State or Foreign http) Camplina
	Maryland f show	or	10a. State 10b. County	A 10c. City,	Town or Location	Himore			0d. Inside City Limits
	with the Pe or 28e-	Direct	10e. Street and Number	Falls Parkway	10f. Zip Code	21:217	10g.	Citizen of What Cou	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any figury or other traumatic event, the Medical Exertifier must be traitlied at ODGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Ø.S. Amed Forces? 1 Yes 2 HO If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Black	
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			e during most of workin ed)	a	Mith Ma	(
	ould be filed within Mental Hygiene. arked other than " atic event, the Me	To Be Con	17. Father's Name (First, Middle, Last) Washington Bow		Mech	18. Mother's Name	(First, Middle, Maid	den Sumame)	
Maryland	1 and 2 should Health and Men tem 27 is marke	Ĕ	19a. Informant's ame/Relationship (Type, Print)	19b. Mailing Address (Stree 2117 Crimea	et and Number or Rural Rd April	Route Number, Cit	ty or Town, State, Zip	Code) 21207 UD,
Baltimore,	. Pages 1 a Iment of Hei tant: If item jury or othe		20a. Method of Disposition 1 Deurial 2 Cremation 3 C Other (Specification 5 Other (Specification)	Removal from State	ce of Disposition (Name of netery, crematory or other pl	ny 2/21	109 La	. Location - City or To ndsdowne	own, State Maryland
Ball	permit. Pag Department Important: any injury o		21. Signature of the ral Service Lies	infer	22. Name and A d	enck Ave	er Funer	ox ma	21229
ł	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	IVE CARDIO			٤	Approxima e Interval Between Onset and Death
8760,	rate be executed by yesician and the burial-transit	al Examiner	Sequentially list conditions, if any heading to annualistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. One to (or as a consequent					
.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 Ectopic pregnan	су		23d. Date of delive	ery Day Year
Δ.	w requires that t been signed by should be detac	by	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause g	iven in Part I.		co use contribute to to	\ /
I Records,		Completed					24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available mpletion of cause of
Vita	Physicien: The I this certificate ha ral director, page	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 DOA	26. Place of Death ther: 4 \(\sum \) Nursing Hom		6 □Other (Specification)	
Division of Vital	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directorial.	atlon: T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury W		8d. Describe how in		<i>y)</i>
Divis	ial or Atters after de ai Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	2	8f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	e Hospital 7 24 hours a le Funerai I	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date and place, a opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
Y	To the within 2 To the complet	Σ	29b. Signature and title of certifier	∩, D		0 59 10 7	29d.	Date signed (Month,	Day, Year)
4			30. Name and address of person who	210 BUSINESS	CENTER DR	NE REIS	TERSTOW	N mp 2	2-1136
	Sta Regist		31. Date filed (Month, Day, Year) FER 2 3 200	32 Registrar's Signatur	- Barket				
DH	MH 17 Rev 1/2	2001		0	RIGINAL				

			For State Registrar	State of Maryland	Certificate of		ivientai riyg Re	eg. No. 2009	05342
	Physici	an	Decedent's Name (First, Middle, Last	1			2. Date of Death		3. Time of Death
and the same	/Medic	al	4a. Facility Name (If not institution, give	Bryan T	4h. City. Town.	or Location of Deatl		4c. County of Death	845 PM
-	Funeral Director	er	Mercy Medical 5. Social Security Number 6. Se	Center	Baltin	nore If Under 24 Hrs.		Baltin	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	Maryla-f sho	ţċ	MD		ltimore				1∭Yes 2□No
	or 28%	Direc	10e. Street and Number	,	10f. Zip Code		10	0g. Citizen of What Cou	untry?
	sath w	Funeral Director		venue		21206	Presify Voc or No-	U S A	ioan Indian
980	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the We-fical Evarther must be rediffied at		11. Marital Status 1 Never Married *** Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cul		to Rican, etc.)	14. Race - Amer Black, White Specify: B J. 5	, etc.
15-0	72 ho "natur	leted	15. Decedent's Edi (Specify only highest grad		6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wor	rking	16b. Kind of Business/I	ndustry
Maryland 21215-0036	within jene. r than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Station N			Amtrak Ra	ailroad
nd	tal Hyg	Be C	17. Father's Name (First, Middle, Last)	14/ A		18. Mother's Nar	me (First, Middle, M	Maiden Surname)	
ryla	2 should be fi and Mental h is marked ot aumatic ever	2	David Bryant				Brown		
Mai	or or =		19a. Informant's Name/Relationship (7 Gwendolyn Brya		19b. Mailing Address <i>(Str</i> ee 4301 Berger			City or Town, State, 2	
ore,	of Health of Health if item 27 I		20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other plane)	ace)	Date	20c. Location - City or 1	own, State
Baltimore,	permit. Page Department of Important: If any Injury or once.		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other <i>(Specify</i>	Gar:	rison Fores	st 2-2		Owings Mi	lls, MD
Bal	permit. Pages 1 Department of P Important: If ite any Injury or ot		21. Signature of Funeral Service Licens	Mg Frank	22. Name and Add	ress of Facility North		ast F/H Balto, M	ID 21202
	Physician /Medical Examiner	1	23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a consequent) b. Ends to	nonia	1.	c or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	rificate be executed ng physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequer Due to (or as a consequer d.	sclerosis				
O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 🗆 Ectopic pregnar			23d. Date of deli Month	very Day Year
S, P	res that signed b be deta	by Pr	Part II. Other significant conditions co	entributing to death but not resulting	ng in the underlying cause g	iven in Part I.	23e. Did tob	bacco use contribute to	the cause of death?
ord	w require s been si should b	ted l					1 □ Y∈	es 2 No 3 Pr	obably 4 Unknown
Vital Records,		Completed	25. Was case referred to medical					med? death? 2 ☑No 1 ☐ Yes	topsy findings available completion of cause of 2 No
F <	Physician: r this certific ral director, I	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 □ DOA	thor:	ath <i>(Ch</i> ec <i>k only on</i> Home 5□ Reside	ence 6 ☐ Other <i>(Sp</i> ec	cify)
Division of	ttending Ph death. ctor: After th y the funeral	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)				ow injury occurred	
) ivis	or Att after de Direct	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time, d	cause(s) and manner as late and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	ma O D	29c. Lice	nse number	2	29d. Date signed (Month	n, Day, Year)
			Karherine	M. tresty	N, DO H	005079	1	2/17/	07
11			30. Name and address of person who contains the contains of the contains the contai	M. Prybys	Jaj (Type, Print)	301 Sa	int Pas	41 Pl. Ba	21202 HU MD

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 05343 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** PATRICIA A. BLEAU FEBRUARY 19, 2009 1:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 8523 OAKLEIGH ROAD If Under 1 Year 11 Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2√□ F Vrs Director 001-30-1650 Usual Residence of Decedent 68 12/31/1940 NEW HAMPSHIRE with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examinar youst be notified at 1 ☐ Yes 2 XNo Director BALTIMORE PARKVILLE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ò 21234 8523 OAKLEIGH ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married "natural", or 1 ☐Yes 2 ☑ No ģ Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 10TH GRADE marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental h ALFRED O. POIRIER PEARL G. LEVEILLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a PENNY M. BUSCEMI/DAUGHTER 7733 WYNBROOK RD. BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 2/21/2009 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses M00217 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic musemall all carenn **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation illed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 29c. License number D 0026575 02/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10155 YORK RD. STE 200 COCKEYSVILLE, MD DAVID J HARTIG MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Marke. Registrar EER 9 9 2000

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mary Frances Bell ,2009 ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner narlestown timore 240 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 F Months Hours Min. Director 579-03-4338 91 9/30/1917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 709 Maiden Choice Lane RGT102 or items 23a 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Completed by Specify: 3 Widowed 4 ☐ Divorced "natural" White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George J. Barkman Clara Storck ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Bell / Son 80 Avon Ridge Avon, CT 06001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Mem Pk 2/24/2009 Elkridge, Maryland 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, MD 21. Signature of Funeral Service Licenses Marke TA 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final rdiovasc **Physician** disease or condition resulting in death) vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performe 2 1 No 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: # investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 10 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Maide -hoice 32. Registrar's Signature 31. Date filed (Month, Day, Year) State EED 9 9 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01377 State of Maryland / Department of Health and Mental Hygiene Leonie Barnes Certificate of Death 1- For State Rea. No Registrar 2. Date of Death dedent's Name (First, Middle,Last Month Day February 16, 2009 Physician/ 1741 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number Baltimore 4109 Ridgewood Avenue #2 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State/or If Under 24Hrs. If Linder 1 Year 7. Age (In yrs, last birthday) **Funeral** Months Day: Hours Min. Country) Director Yrs Usual Residence of Decedent 10d. Inside City Limits or/Location 10b. County 10a Yes 2 28a-f show s 23a or 28a-f show e notified at once. hours after death with the Maryland Director 10f. Zip Code 10e. Stre Race - American Indian, Black, Was Decedent of Hispanic Drigin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married Yes 2 No specify: Specify ō f Yes. Give Year Yes Divorced Widowed "natural" à 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. 90 NOT use retired) Completed Elementary Secondary (0-12) other than 21215-0036 Pages 1 and 2 should be filed within hent of Health and Mental Hygiene If item 27 is marked Be 2 Baltimore, 3 Removal from State Cremation Important: Dther Spec Donation 5 ignature of Funeral Service art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Retween Onset and Physician failure. List only one cause on each line Death Medical HIV infection/ AIDS Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and 3/6/09 23a,P11,2/,perME, G889 Physician/Medical XUNPENDED AMENDED physician a 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death use as past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? the certificate has been signed by the ector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. No 3 Probably 4 V Unknown ğ Cocaine use 24b. Were autopsy findings available Completed 24a. Was ar prior to completion of cause of autopsy death? performed? No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Dther4 Residence 6 V Other: Scene Hospital: Nursing Home 5 examiner? FR/Dutpatient 3 DOA Inpatient 2 After this 1: ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 X Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fun Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 • Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day. Year) 29c. License number 29b. Signature and title of certifie February 17, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD

DHMH 17 Rev 1/2001 DCME 2006

State Registrar 31. Date filed (Month, Day, Year,

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: Amend Item State of Maryland / Department of Health and Mental Hygien () Certificate of Death Reg. No. 1 - For State Registrar 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 500 whyhat /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death Examiner If Under 1 Year Timose nd Date of Birth (Month, Day, 7. Age (In yrs. 9. Birthplace (State or Foreign Coupty) **Funeral** Months Year 80 1 □ M 2 X Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location worle the Madical Examiner count be notified at es 2X No Director 28a-1 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numb 5 238 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married **Elack** 1 ☐ Yes 2 No 0 Maryland 21215-0036 Specify: Specify 3 Widowed 4 □ Divorced "netural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SUDLIVISI)Y 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiane. College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygia If Item 27 is marked other to prother traumatic event, in Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be James 19b. Mailing Address (Street and Number or Rural Route Number_ Depertment of Health an important: if item 27 is now injury or other trau 8325 Mary
Place of Disposition (Name of vonne salto. COBA Baltimore, 20a. Method of Disposition cemetery, cremator 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uch as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** MINEN 4d /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner inding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) been signed by the attending physicien should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Stunknown 2X No 1 ☐ Yes 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 22 No 1 ☐ Yes this certificated and director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA within 24 hours aftar death.
To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide t Contifying Physician: To the best of my knowledge death occurred at the time, date and plane, and due to the dause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23s Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alica 10.225h 82. Registrar's Signature 31. Date filed Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Rawles Blackman February 2009 1212 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lutheran tugsburg Baltimore If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year, 03 28 19 Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 5704 1 □ M 2 X F 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore MD 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3513 FairView 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant Cook 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) Baltimore MD 21215 Fanc -ageWood Road SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Woodlawn, MD 4 □ Donation 5 □ Other (Specify) Woodlawn 23 09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jaugha C. Greene Funeral Sorvices Voush C. Road Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Dispase disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown completely filled in by the funeral director, page 2 should be detacled. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2☑No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who complete

Year)

0 2009

31. Date filed (Month, Day,

Zibell

Mb

32. Registrar's Signature

Mani

of death (Item 23a) (Type, Print)

25

D37573

-16,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** IVE rebruggy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** NOV. 12,1926 Director NONE BERMUDA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No NA 10e. Street and Number 10g. Citizen of What Country? ō BERMUDA PGOQ items 23a PININIACIE by Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No 3 ¥ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GTH GRADE OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALEXANDRA JOHN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 GILBERT HILL, SMITH, BERMUDA FLOS LINDA TERRA (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. PAUL'S CEMETERY OS/27/2009 PAGET, BERMUDA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JR. FUNERAL HOME JOSEPH H. BRUWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses Melamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or a consequence of): **Physician** tailure disease or condition resulting in death) /Medical Examiner my o cardeal Sequentially list conditions, I any leaf of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician ar Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **^** 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b 1 🗌 Yes 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4
Nursing Home ၉ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident ector; 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide

Division of Vital Records, P.O. Box 68760, Hospitai 24 hours the

filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi (check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 M.D. tegrian 20,200 30. Name and address of person who complete scause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 20

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05349 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:35 PM FEB 2009 Richard E. Craig /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 27, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 ☐ F 78 **Director** Maryland 218-28-0958 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. It has a 72 is marked other than "natural", or Items 23a or 28a-f show 72 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Director Baltimore Catonsville 1 □Yes 2√ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 709 Maiden Choice Lane RG4S 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 lab technician healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl William Craig Vinnie Mae Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Patricia Shaw/sister 1442 Putty Hill Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☑ Donation 5 ☐ Other Specify) 21. Signature of Euneral Service Licensee Ronald S. Wader Director State Anatomy Board 655 W. B

Baltimore MD 21201

23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronald Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 ER/Outpatient 3 DOA 2 nours after death.

neral Director: After this
filled in by the funeral d 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division or 1841

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FFR23

2

Till

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VITBERG

900 CATON

\$2. Registrar's Signature

29c. License number

AVENUE

D 6430 7

BALTIMORÉ

29d. Date signed (Month, Day, Year)

21229

16, 2009

F5BRJARY

		Please 1 - For State Registrar			/ Depa		dealth a	re All Copies and Mental Hy		2009	05350
Physicia /Medic		Decedent's Name (First, Middle, La George	*	urtne				2. Date of De Month Febru	eath Day		3. Time of Death
Examin		4a. Facility Name (If not institution, giv Stella Maris Ho				4b. City, Town, o	son		4c.	County of Death	
Funeral Director		5. Social Security Number 6. S 215-20-8297	Sex 7. Age	e (In yrs. last 82	birthday) Yrs.	If Under 1 Year Months Days	Hours	24 Hrs. 8. Date of Bi (Month, D		Cou	place (State or Foreign intry) Virginia
Maryland a-f show	ctor	10a. State 10b. County Maryland Baltime	ore	10c. City, To	own or Lo						10d. Inside City Limits 1 □Yes 2 🛂No
ith with the 23a or 28	Funeral Director	10e. Street and Number 6537 St. Helena A	venue			10f. Zip Code 212	22		10g. Citi	zen of What Cou USA	ntry?
perfull Design Mary yield A LA 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marieal Exprinter man be neithed at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 [X]Yes 2 [1] If Yes, Give Year or Dates:	Ever in U.S. No		Was Decedent of H If Yes, specify Cub 1 □Yes 2 No	lispanic Ori an, Mexicar Specify:	gin? (Specify Yes or N i, Puerto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Wh	
within 72 ho ene. than "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 6 Years	ducation ade completed) College (1-4or 5	1	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Fitter	during mos	t of working		nd of Business/Ir Boat	ndustry
VIGILO A	To Be Co	17. Father's Name (First, Middle, Last John Courtney)					er's Name (First, Middle a Breakall			
and 2 sho ealth and n 27 is maner		19a. Informant's Name/Relationship (Doris Courtney	(Type. Print) Wife	6	537 \$	St. Heler		er or Rural Route Numi nue, Dunda			
callimote rmit. Pages 1 a spartment of He portant: If iten y injury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ceme	etery, crer	sition (Name of matory or other pla Crematory		ebruary 21, 2009	1	cation - City or To Cimore, I	
permit Depart Import any inj		21. Signature of Fundral Service Lice	Come	lles	. di	onneily 110 Solle	unera ers Po	1 Home of I int Road, I	Dunda Dunda	alk,P.A. alk,Md.	21222
Physician /Medical		23a. Part 1. Enter the disease of com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line. a. LUNG C. Due to (or as	ANCER		er the mode of dyi	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
ifficate be executed g physician and as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease on injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.								
box aath cert attendin for use a	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of deliv Month	very Day Year
law requires that the de as been signed by the 2 should be detached	ed by P	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause giv	ven in Part I.				the cause of death?
al neccinity of the law relicate has be	Completed							24a. Was auto perf 1 □ Yes	psy ormed?		opsy findings available ompletion of cause of 2 No
n VICAL hysician: T his certificat I director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ☐ ER	/Outpatier	nt 3 🗆 DOA Oth		of Death (Check only ursing Home 5 Res		6 X iOther (Speci	ify) HOSPICE
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be		y, Year)	b. Time o Injury	M 1	ryat k?]Yes 2□I				
pital or Al nurs after of eral Direc		4 Homicide determined	building, et	c. (Specify)		eet, factory, office		City or To	wn, State)	al Route Number,
thin 24 ho the Fund the Fund	Medical	29a. Certifier (Check only 2 Medical Exaone) X Nurse Prace 29b. Signature and Aitle of ≰ertifier	miner: On the basis o	f examination	and/or in	vestigation, in my	opinion, dea	nd place, and due to the	, date and	place, and due t	to the cause(s)
) 1 × 1 × 1		> Sylvest	anp	anth /ltom 00	to) /Tuno	B14	979	2	230. 0	20/200	9
U √ Sta	te	30. Name and address of person who JACKIE JONES, Cl 31. Date filed (Mohiti, Day, Year)	RNP 2300 32 Tegistro	DULANE ar's Signature	Y VAI	LLEY RD.	TIMO	NIUM, MD 2	1093		
Registr	ar	FEB 2 3 20	09 Senson	w B.	for the	aked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05351 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:40 PM WILLIAM LEROY CHANDLER 16, 2009 FEB. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER BALTIMORE Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Davs Hours 1 ★M 2 □ F 217-37-9989 MAY 16, 1942 66 MD Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 Tx Yes 2 □ No BALTIMORE PERRY HALI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4004 SILVER SPRING RD. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ∐Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH MAINTENANCE RESIDENTIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROY CHANDLER EASTER WELLS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AISHA SHIELDS/DAUGHTER 1703 HARLEM AVE. - APT. #1, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 5500 O'DONNELL ST. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/21/2009 BALTIMORE, MD 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Foneral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD Part . Enter the dise set, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Approximate Interval Between Onset and Death mmediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY YEARS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 X Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Physician

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Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Evantiner must be mutified at

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Health a If item 27 or other t

27 is marked traumatic e

Injury or

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Physician/Medical

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Certification: To

After this

after death

within 24 hours a

funeral

filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant

24a. Was an 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Hospital: 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28d. Describe how injury occurred

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D64395

29d. Date signed (Month, Day, Year) FEBRUARY 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, SUITE 209 BALTIMORE MO 21204 DANIEUE DOBERMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

09-01429	
Adrian Cox	

drian Cox	1- For State Registrar	State of Mar	ryland / Departr <i>Certifi</i>	ment of Healicate of Deale			20 (09 05352
Physician/ Medical Examiner	Decedent's Name (Fig. 1)	rst, Middle, Last)	Cox				Day Year y 18, 2009	3. Time of Death 1015 hrs
		institution, give street ar Ivedere Avenue	nd number)		y, Town, or Location of timore	of Death	4c. County of Dea	·A
Funeral Director	5. Social Security Numb	A .	7: Age (In yrs. last t		nder 1 Year If Unde nths Days Hours			Birthplace (State or eign Country) Carolina
any.	Usual Residence of Dec 10a. State 10b.	County .	10c. City, To	wn or Location				10d. Inside City Limits
yland 1- show a 1- once	10e. Street and Number	NIA	130	2ltim	Zip Code		10g. Citizen of What Co	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	3800 W	1. Belve	rdere Av	e 511	21215		USF	
death wi	11: Marital Status 1 Never Married 3 Widowed			If Yes, sp	edent of Hispanic Orig ecify Cuban, Mexican 2 No specify:	gin? (Specify Yes or , Puerto Rican, etc.)	No- 14. Race - Am White, etc. Specify: B	
15-0036 filed within 72 hours after I Hygiene. ed other than "natural", of the Medical Examiner.	15. Decedent's Educa Elementary/Seconda	tion (Specify only highes ry (0-12) Colle	t grade completed) 16 ge (1-4 or 5+)		ual Occupation (Give working life. DO NOT		16b. Kind of Busines	a ble
Q 3 8 8 8 9 Q	Willie 1	it, Middle, Last) Murriel			18.Mother	's Name (First, Middl 19uelin	re Cox	
MD 21. d 2 should the hand Mer in 27 is man aumatic even	19a. Informant's Name/	Relationship (Type, Print	father	5 San	ress (Street and Nun	nber or Rural Route I C+ . #	Number, City or Town, Sta Pikes VIILe	ate, Zip Code) Mi) 2i208
altimore, Mrmit. Pages I and partment of Health protant: If item jury or other trau	20a. Metrod of Disposi 1 Burial 2 0 4 Donation 5	tion Cremation 3 Remo	20b. Place oval from State	ce of Disposition (matory or other pla		2/27/09	20c. Location - City	or Town, State Mills, MD
Baltir permit. F Departme Importar injury or	21. Signature of Funera	al Service Licerisee	1 .	22. Name	and Address of Facility Liberty	Heights	i Ave. Bal	to MD ZIZOT
Physician /Medical	23a. Part I. Enter the di failure. List only of Immediate Cause (Fina	isease, or complications one cause on each line.	that caused the death. Do	o not enter the mo	de of dying, such as d	cardiac or r 🚧 iratory	arrest, shock, or heart	Approximate Interval Between Onset and Death
`xaminer	or condition resulting in	Due to (o	r as a consequence of):	- "				
red Insit Examiner	Sequentially list condition if any, leading to imme cause. Enter Underlyin (Disease or injury that events resulting in dea	diate Due to (or ng Cause initiated C.	r as a consequence of):					
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50, Ite be execut nysician and burial - tra		AMENI 23c. If	yes, outcome of pregnar				23d. Date of deliv	very
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the be nedical Certification: To Be Completed by Physician/Me	23b. Was decedent prepast 12 months?	gnant in the	Live birth Pregnant at time of death Unknown	2 Fetal de		ic pregnancy	Month	Day Year
O. Bat the data the d		ant conditions contribu		ulting in the under	lying cause given in P		id tobacco use contribute	
Records, P.(The law requires tha ficate has been signed page 2 should be det	<u>Chronic</u>	alcohol ab	use			1		Probably 4 Unknown
cord law red has bee 2 shou						a	utopsy prior erformed? death	to completion of cause of
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Vital ysiciam ysiciam his certi directo	examiner?	No Hospital:	Inpatient 2 E	R/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 O	ther: Scene
ing Ph After t funeral	27 Manner of Death		(Month, Day, Year)	8b. Time of Injury	28c. Injury at Wor	_ I	ibe how injury occurred able fall	
Sion Attend death. death.	Natural 5	Investigation F	d 2/18/09 F	rd 10:05	am	etc. 28f. Locati	on (Street and Number or	Rural Route Number, City
Division o spital or Attending yours after death. neral Director: After filled in by the fune	3 Suicide 6 4 Homicide	Could not be	hecify) house	io, idilli, stroot, idi	otory, omoo banang, t	or Tov Balt	n, State) 3800 W.	Belvedere Av
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dividing after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. Medical Certification: To Re Completed by Physician		ertifying Physician: To the edical Examiner: On the and ma	ne best of my knowledge basis of examination and nner stated.	e, death occurred a d/or investigation, i	in my opinion, death o	ccurred at the time, o	late and place, and due t	o the cause(s)
	29b. Signature and title	e of certifier			29c. License numbe	г	February 19, 2	
	June	dig outher	11, MD	33)	O.C.M.E.			
\$ OK pend	30. Name and address Pamela E. So	of person who complete uthall, MD Assis	d cause of death (Item 2 tant Medical Exam		enn Street, Baltii	more, MD 2120	1	×
Stat	411	Day, Year)	32. Registrar's Signature		1			
Registra	r tt	B 2 3 2009	person for	· Segrician				

			For State Registrar	State of M	laryland .	Depa / Depa	artment o rtificate d	f Health of Death	and M	lental Hy	giene Reg. No.	200	19	0535
			1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath			. Time of Death
	Physic /Medi		Gloria N. DeMar	co						Month Februa	ry 9		6	:30 AM M
-	Exami		4a. Facility Name (If not institution, give	e street and number	r)		4b. City, Tow	n, or Location	of Death			County of De		
and the			3601 Greenway #	502			Ba1	Ltimore						
	Funeral		Social Security Number 6. S		ge (In yrs. last		If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. E	Birthplace Country)	e (State or Foreign
	Director		213-40-3000	□M 2 💢 F	78	Yrs.	William De	.,,		June 2,	193	0 Ma	ary1	and
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d	Inside City Limits
	f sho	5	MD			1timo								1√2 Yes 2 □ No
	28a-	ect	10e. Street and Number		Da	I C IIII	10f. Zip Cod	de .			10g Citiz	zen of What		21
	with yard	Ö	3601 Greenway #50	2				21218			109. 01112	USA	oountry.	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Evartirer must be notified at	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.			rigin? (Sp	ecify Yes or No	- 1	I4. Race - Ai	merican I	Indian.
"	r iter	Ξ	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🕅	?		f Yes, specify (Cuban, Mexica	ın, Puerto	Rican, etc.)		Black, Wi		
03	ar",o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 □ Yes 2 1	No Specify	<i>'</i> :			Specify:	whit	e
2-0	72 ho	Completed	15. Decedent's E	fucation	1	6a. Dece	dent's Usual Oc	ccupation	et of worki	ing	16b. Kin	nd of Busines	ss/Indust	ry
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yla	2 should be fi and Mental H Is marked of aumatic evel	မ	Joseph Naddeo						a Re					
Maryland 21215-0036	t 2 sh h and 7 Is n traun		19a. Informant's Name/Relationship (Francis DeMarco/s		1		-			_{al Route Numb} 1timore	-	Town, State 2121		de)
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Baltimore,	e = 12 €		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special		cemi	etery, crer	sition (Name o natory or other	place)		Jake	200. Lot	cation - Oity	or rown,	State
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Division	tal or Attending Pt s after death. al Director: After the ed in by the funeral	Certification:	1 Natural 5 Pending investigatio 3 Suicide 6 Could not b determined	28e. Place of Ir		Injury , farm, str	M	Work? 1 □ Yes 2 □ ice	-	28f. Location (S City or Tox	Street and vn, State)	l Number or	Rural Ro	oute Number,
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	Fo the within 2 Fo the somple	Me	29b. Signature and title of certifier				29c. Lic	ense number			29d. Date	e signed (Mo	onth, Day	; Year)
	. > - 0		mananout	1 200	Den A	1.10	D	2000	000	3		0/11/	1-00	
			30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type.	Print)	1003	V4 /			1/11/0	1009	7
			MARGUER ITE T.		,	EAST	3310	STOPO	t ./	BAITIN	100	MA	212	218
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 05354 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death th Month Day Year **Physician** 2001 John H. Davis Eproal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner Baltimore** Season Hospice Randallstown 8. Date of Birth (Month, Day, Year) 05-01-1952 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 M 2 ☐ F Months Days Hours Min. MD 216-54-6822 56 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 X Yes 2 ☐ No Director Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 2400 Marbourne Ave Apt 1D Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? 1. XYes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. SpecifyAfrican American 3 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Solo Cup Company Machinist 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Lee Davis 2 John Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 Marbourne Ave Apt 1D Baltimore, MD 21230 Rosa Lee Davis /Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-26-2009 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21, Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Encephalopath disease or condition resulting in death) Due to (or as a consequency of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Vear Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify 105 P1 (6 1 Yes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

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Medical

Division of Vital Records, P.O. Box 68760, ζ

Funeral

Director

Physician

/Medical

Examiner

6 Could not be determined 4 Homicide

29a. Certifier

(Check only

29b. Signature and title of certifier

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2835 SmHa BWoon 31. Date filed (Month, Day, Vear) 32. Registrads Signature

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 12:58 AM DEMB FEBRUARY PRISCILLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/03/1921 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 21XF 87 214-20-1130 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County ed other than "natural", or items 23a or 28a-f show event, the Wedical Examiner must be notified at 1 XYes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 21208 USA 3211 SHELBURNE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 X No Specify Completed by 3 Nidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Pages 1 and 2 should be filed within 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f. Department of Health and Mental I Important: If Item 27 is marked ot any Injury or other traumatic even FRIEDMAN CAPLAN FREIDA JUL I US ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE MONDELL / DAUGHTER 7607 LORRY LANE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 02/20/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1all 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** unhum Spiration /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Ramsayburial-trai The law requires that the death certificate be execu Due to (or as a consequence of P.O. Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, been signe should be d Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Worlstd 1 ☐Yes 2 ☐ No 2/No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
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filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours a 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 00060240 unewall North Charles Street Bultmore of person who completed cause of death (Item 23a) (Type, Print) Greenanal MD 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dayth Month Year **Physician** FEBRURRY BUIS DADE, 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ORTH RANDAUSTOWN BALTIMORE WEJ If Under 1 Year | If Under 24 Hrs. | 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Hours 216.20.1447 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show Windsor Mill 1 ☐ Yes 2 No Baltimore Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Martield Avenue 21244 USA 34F)(0 Funeral 14. Race - American Indian, Black, White, etc. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2001 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Mail Carrier 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Dade, illy Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Mayfield Avenue Windsor Mill MD 21244 permit. Pages 1 and 2 s
Department of Health an
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1 ☐ Yes 2 ☐No 24a. Was an 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No illed in by the f 2. Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of cartifier 3009

State Registrar JOGINDER

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

JUN HEAVE 31. Date filed (Month, Day,

HUTPITHI

Registrar's Signature

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			For State Registrar	State of M	larylan	d / Dep <i>Ce</i>	artment of F	lealth a Death	and Mer		giene (9	05357
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho intury or other fraunatic event, the Medical Examiner must be notified at once.	Comple	-11- 17. Father's Name (First, Middle, La	-0-	-	LA	BORER	1			CONSTR	UCTION	
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To the Ho within 24 To the Fin	Medical	(Check only Certifying Phys	sician: To the best ner:On the basis of and manner sta	f examination an	e, death occur id/or investigat	red at the time, ion, in my opini	date and pion, death o	place, and occurred a	due to the caus t the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)	
E.3 E.8	₩	29b. Signature and title of certifier	and mailler Sta	aigu.			ense numbe	er	-	29d. Date signed	(Month, Day, Year)	
		30. Name and address of person wh	hall mu	e of death /Itom	23a)	0.0	C.M.E.			February 17,	2009	

State 31. Date filed (Month, Day, Year)

Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene? 05359 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 17 2009 RONALD **ELLISON** 1:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year, 06/06/1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 X M 2 ☐ F Months Days Hours Min. 219-38-4851 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event. The Monthell Events 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 WEST 39TH STREET, #1515 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No ģ Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID ELLISON PAULINE WEINSTEIN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANN RODGERS / COUSIN 12104 RIDGE VALLEY DR., OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of ARIE 11 NG TO Nato CHTZU Race) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State AMUNO CONG. 4 ☐ Donation 5 ☐ Other (Specify) 02/20/2009 BALTIMORE, MD Signature of Funeral Service Deepsee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the dis section pirations that caure shock, or heart failure. List only one cause on early li Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-transil Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 5 24a. Was an autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours
of the Funeral D'
completely fille 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29b. Signature and title of certiff 1)449 Physician, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 494 Eas Krave 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760.

P.O. I

of Vital

Division

Amend # 16b per FH 888 2/23/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, 8, per Inf C888 2/26/09 TT State of Maryland / Department of Health and Mental Hygiene 05360 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY " 19 2009 **ESTRIN** HARVEY LEE 8:02 A /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 18 BLONDELL COURT TIMONIUM BALTIMORE 8. Date of Birth May (Month, Day, Year) 05/15/1945 9. Birthplace (State or Foreign NY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 63 Director 078-34-5654 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, I'm Mulcai Exprine Counting by rottling at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 □Yes 2 X No Director MD BALTIMORE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 BLONDELL COURT 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🕅 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Advertising Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION MANAGER **ARCHITECTURE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ESTRIN** HARRY SADIE LISTIZKY ည 19a. Informant's Name/Relationship (Type. Print)

Kodera Fstrin

ELAYNE ESTRIN / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 BLONDELL COURT, TIMONIUM, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH MOSES 02/20/2009 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lipensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 TYPS 2 No 9 ☐ Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performad? 1 □ Yes 2 🖸 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 🛮 🗽 Fritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0062100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAND 1650 ORLEANS STREET 200M 407 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

09-01452 Irvin Alonzo Fraction

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 05361

		1- For State		Certificate of I	Death	Reg	No.	
Physic	cian/	1. Decedent's Name (Fin				2. Date of Death	Day Year	3. Time of Death
/ied:cal Exar		irvin	traction			February 18	3, 2009	1544 hrs
		4a. Facility Name (if not 3712 Lamoine	institution, give street and number) Road	45	City, Town, or Location o Randallstown		4c. County of Dea Baltimore Co	unty
Funera Directo		5. Social Security Numb	6. Sex 7. Age	(In yrs. last birthday) 31 Yrs.	If Under 1 Year If Unde Months Days Hours		1 0	irthplace (State or Foreign ountry) Maryland
ow any				10c. City, Town or Locatio	Baltimor	v	1,	10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f show	al Director	Maryland 10e. Street and Number 2802 Har	dem Ave,		10f. Zip Code 21216	100	Citizen of What Co	A
death with the Maryland or items 23a or 28a- she	Funeral I	11. Marital Status 1 Never Married	2 Married 12. Was Decedent Armed Forces? 1 Yes 2	If Ye	Decedent of Hispanic Ong s, specify Cuban, Mexican,	in? ('Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame White, etc. Specify: Bla	erican Indian, Black,
hours after	2	3 Widowed 15. Decedent's Educa Elementary/Seconda	4 Divorced of Specify only highest grade community (0-12) College (1-4 or 5	pleted) 16a. Decedent' during mo	Yes 2 No specify: s Usual Occupation (Give I st of working life. DO NOT	kind of work done use retired)	Specify: 16b, Kind of Business	s/Industry
215-0036 be filed within 72 ntal Hygiene. rked other than "	Completed	17. Father's Name (Firs			_aborer	's Name (First, Middle, M	aiden Surname)	110~
C s ta x	B B	Imn to	raction		Alic	e Faulkn	er	Tip Code)
MD 21 d 2 should th and Mer n 27 is mar	To	Crystal 1		-002	Address (Street and Nun Harlem A	Ma Baltima Date	Der, City or Town, Sta 20c. Location - Pity	141
more, M Pages I and 2 nent of Health ant: If item 2	or other tra	20a. Method of Disposi 1 Burial 2 4 Donation 5	tion Cremation 3 Removal from Sta Other Specify:	orematory or oth Att. Zion	Cemetery	2/28/09	Landsdo	me Maryland
Balti permit Departin Importe	rujury	21. Signature of Funer	vin tarken	357	ame and Address or Facility	-Ave. Bath	mare, Ma	Mar 21229 Approximate Interval
Physicia 'M dic xamin	al	failure. List only of Immediate Cause (Final		ot Wound of Head	e mode or dying, such as t		31, 311031, 51 110311	Between Onset and Death
	i di	or condition resulting in Sequentially list condit if any, leading to imme	ions, b.					.,
pa	nsit Land	(Disease or injury that events resulting in dea	initiated c. Due to (or as a conse	equence of):	·			
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Box 68760, e death certificate be the attending physici	ched for use as the burial - transit Physician/Medical Ex		4 Pregnant at	2 Fe	al death 3 Ectop	ic pregnancy	23d. Date of deliving Month	rery Day Year
P.O. B. sthat the de	detached i		ant conditions contributing to deat	h but not resulting in the u	nderlying cause given in P	u.,		to the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	funeral director, page 2 should be detached					24a. Was a autop perfor	sy prior med? death	
Re : The ificate	r, pag		to medical		26.Place of Death	(Check only one)		
/ital sician is cert	lirecto	examiner?	I I amital:	ent 2 ER/Outpatient	3 DOA Other	Nursing Home 5	Residence 6 🗸 O	ther: Scene
on of V nding Phy th :: After th	e funeral dir		28a. Date of Injune 15 Pending Feb 18, 2005	(ear) 28b. Time of I 1537 hrs	njury 28c. Injury at Wor 1 Yes 2 ▼	 Subject sho 	now injury occurred t self	
Divisior tal or Attend rs after death	filled in by the fune	2 Accident 3 Suicide 6	Could not be	njury - At home, farm, streengle Family	et, factory, office building, o		Street and Number or state) e Road, Randallsto	Rural Route Number, City
To the Hospita within 24 hours	completely filled in by the funeral director, page 2 should		ertifying Physician: To the best of n edical Examiner:On the basis of exa and manner stated	ny knowledge, death occur amination and/or investiga	rred at the time, date and p tion, in my opinion, death c	lace, and due to the caus occurred at the time, date	and place, and due t	o the cause(s)
	00	29b. Signature and)	29c. License numbe O.C.M.E.	er .	February 19, 2	
1	=		s of person who completed cause of		Penn Street, Baltimo	re. MD 21201		
	Stat			ar's Signature		10, WD 21201		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2001 /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, Year) 8-14-1958 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 □ Months Days Hours Min. 50 214-74-2945 MD Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evaminer must be notified at **Funeral Director** 1
Yes 2 □ No BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US Α 1807 Dundalk Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2/☐ No Specify þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Genesis Elder Elementary/Secondary (0-12) College (1-4or 5+) Dietary Care and Mental Hygie is marked other the 12th grade N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fleming Carlie Streat Laura ပ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Nathaniel Griffin, Sr Balto, MD 21222 1807 Dundalk Avenue other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₹ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. <u>≒</u> 5 2-13-2009 Crownsville, MD Crownsville Vet 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H ordrae MD 21202 North Avenue Balto, 1101 E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician purous disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examine tany leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣No 24a. Was an 2 **27**0 certificate 1 □Yes Be (funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 To the I the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ath (Item 23a) (Type, Print) State Registrar

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*	Examir		4a. Facility Name (If not institution	give street and nu	mber)		4b. City, Town,	or Location of	of Death		4c. County of	f Death	
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	Funeral Director		5. Social Security Number 216-72-2778	6. Sex Magazia para 2 and 1 a	7. Age (In yrs.)	i <i>ast birtnd</i> a <i>y)</i> Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day	Year)	9. Birthplac Country	e (State or Foreign
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pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	,				18. Mothe	r's Name (F	irst, Middle, I	Maiden Sumame)		•
yla		은	James E. Gro					Heler	n R.	Hardi	ng		
Maryland	C1 c2 - c5		19a. Informant's Name/Relationsh Shirnette Fe		Concin	19b. Mailin	ng Address (Stree	t and Numbe	or or Rural R	oute Number	, City or Town, St	ate, Zip Co	ode) 21208
	is 1 and of Health itam 27 othar tr		20a. Method of Disposition	rguson-c			21 Scot	.ts Le	Date	-	P1Kes ¹ 20c. Location - C		
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Ē	보는 보다를 .		* 4 ☐Donation 5 ☐ Other (Sc 21. Signature of Funeral Service L		Mei		remator 2. Name and Addr			3/09_	Baltimo	ore,	Md
Ba	permi Depa impo any i		1	XX.	0 0	Ma	rch F/E	West	_				
	_		23a. Par 1. Enter the disease, or	complications that c	sused the death	n. Do not ent	00 Waba er the mode of dy	ing, such as	7 ∈ ∤ B cardiac or re	altim espiratory arre	ore, Mo	Ar	1215 oproximate
	Enysician :		Immediate Cause (Final	niy one cause on e	ac n ino .			3.1.			100	Int	terval Between nset and Death
	/Medical		disease or condition resulting in death)	a.	√ ℓ √ √ (or as a consequence of the cons	uence of):	lure	WILI	1 (0)	agui	opath	4	
	Examiner				blohr		: at	sce	55	230		· ·	
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	or a a consequ								
	ecute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	oas		scess						
8760,	rate be executed physicien and the burial-transit		resulting in death) cast	Due to (or as a consequ	ience of):	AIT	15					
87	physicate t	dicai		d	101 311	and c	/ \ [
P.O. Box 6	The law requires thet the death certific tte has been signed by the attending p page 2 should be detached for use es'	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnal irth 2 ☐ Fetal ant at time of de own	death 3	Ectopic pregnance Other (specify)	ey			23d. Date of Month	,	y Year
	ires thet signed b	by PI	Part II. Other significant condition	s contributing to de	ath but not resu	ılting in the u	nderlying cause gi	ven in Part I.		23e. Did tob	acco use contrib	ute to the c	ause of death?
Division of Vital Records,	w requires been sig	ed b							1	1 ☐ Ye	s 250No 3	☐ Probably	y 4 🗌 Unknown
000	aw requ is been 2 should	Completed								24a. Was ar	24b. We	re autopsy	findings available
ă	The law ate has l	mo.								autops perform	ned? dea	ath?	etion of cause of
ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (C	heck only on			
Ž	Physic this coral dire	ဥ	1 ☐ Yes 2 XNo			ER/Outpatien	I SI DOA		rsing Home	5 🗆 Reside	nce 6 Other	(Specify)	
n	ing P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28c. Inju Wo			Describe ho	w injury occurred		
S	ttand death tor: /	cati	2 Accident investigation investigation and investigation investigation and investigation investigat	ot be		,		Yes 2□N	_				
<u>></u>	or All after of Dirac in by	Certification:	4 Homicide determin	286. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office		28f.	City or Town	reet and Number , State)	or Rural Ro	oute Number,
_	To the Hospitel or Attanding Physician: The within 24 hours after death. To tha Funeral Diractor: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 X Certifying	Physician: To the	best of my know	vledge death	occurred at the t	me date and	t place, and	due to the ca	use/s) and mann	or as state	d
	24 h a Fur	Medicai	(Check only 2 Medical E	xaminer: On the ba	asis of examinati	ion and/or inv	estigation, in my	opinion, deat	h occurred a	it the time, da	ite and place, and	d due to the	cause(s)
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licen				d. Date signed (/	Month, Day	r, Year)
١.			Saimo	Chor	way	n	DOC	588	065	Fe	bruary	120t	h 2009
7 ₁ \	V 1		30. Name and address of person w	no completed caus	e of death Item	23а) (Туре,	Print)	9 4	bert	4 RO	ad 6		
_	\ V			AWAS	JA, M	. D	Rar	dall	stov	y Ro.	10 21	133	5
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ure							
	Registr	-	FEB23	2009	Billion L	h do	chal						
DHI	VIH 17 Rev 1/20	001	r nin bar t⊖r (√ (and have		ORIGINA							
					•		1 1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 05364 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 17, 2009 ELIZABETH MAE GALLIS 21:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Days Hours Min Year) 1934 74 Virginia Director 228-40-0152 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov or other traumatic event, the Medical Examiner must be nutfilled at 1√XYes 2□No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 20707 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any Injury or other traumatic event 15445 Arbory Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XXo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🗵 **X**o ò Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 year NSA Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Crump Nell Elizabeth Landis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Dwyer daughter 6404 Forest Mill Lane Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 🛣 remation 3 ☐ Removal from State Arundel Crematory: 2/20/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²Bonaidsonssfumeral Home, P.A. / M00770 Laurel, Maryland 313 Talbott Avenue 20707 23a. Part 1. Em r the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duri to for as a constant one; off To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the aid be detached for Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 🗷 Inknown Completed peen Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy 1 ☐ Yes 2 🛛 **X**o 1 □ Yes 2 **XX**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🛛 💥 🕽 o Certification: To 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injurv 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Kartifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0064760 February 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road Dr. Mythily Vancha Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 2 3 2009

State of Maryland / Department of Health and Mental Hygiene 2009 05365 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 21, 2009 **Physician** Charlotte Diane Gooderham 5:35 aм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Linthicum Hospice of the Chesapeake Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | March 22, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 M 2 F Yrs. Director 62 PA <u>217-44-5207</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or itema 23a or 28e-f show amy injury or other traumatic event, I've Medical Evaninar must be notified at once. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Anne Arundel Annapolis Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1129 Mainsail Drive 21403 U.S.A. Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Forrest Rumsey Charlotte Yancofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Kolmar St. Unit B La Jolla, CA <u> Silver Gooderham / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Crematory 2/22/2009 Hanover, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorqta W. Marshal f2. Name and Address of Facility Maryland Cremation Services usal P.O. Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death METASTATIC **Physician** BANDDER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consecuence of Examiner requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospitai or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 K ther (Specify) 1 ☐ Yes 2 No 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation r death, 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tile of certifie 29d. Qate signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 31. Date filed (Mo legistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05366 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Walter **Physician** Leroy Gordon 10.00 AM 2009 reb /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A BALTINORE SINAI HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) B. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2□ F MD 212:34:2423 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Modical Examiner must be notified at once. Baltimore NIA 1 Mes 2 □ No Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 5811 Bland USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlehem College (1-4or 5+) Elementary/Secondary (0-12) Welder 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Ingram Marie Gordon ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5811 Bland Avenue Baltinione MD 21215 Priscilla Gordon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State unson Fovest 02/26/09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funday SVCS 21. Signature of Funeral Service Licensee Vaush Liberty Road Randallstown ND 21133 23a. Part 1. Ent. (the visease, or complications that caused the death. Do not enter the mode of dying, su h) is cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line, Immediate Cause (Final EM 60 40 Week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): wee of Examiner Staye Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Due to (or as a consequence of): Physician/Medical the attending ph IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ∐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after dear filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled 29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - CHANDRA (EMMASANI, M) D006312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA PEMUSSA Suite 212 A Paltimore, MD 2/2/1 40th st 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:00 AM 2009 DENISE ANN HARRIS FEB /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4401 W. FOREST PARK AVE. 1ST FL. BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🔀 F 25, 1953 Director 55 NOV. MD 217-86-5204 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1X Yes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4401 W. FOREST PARK AVE. - 1ST FL. USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo BLACK Specify: q 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical ponce. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DIETARY NURSING HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ LEROY MARSHALL EMMA_KING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES W. HARRIS/HUSBAND 4401 W. FOREST PARK AVE., 1ST FL., BALTIMORE, 20c. Location - City or Town, State 20a. Method of Disposition Oaklawnocesterery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-16-09 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD GARRISON FOREST 22. Name and Address of Facility 21. Signature of Funeral Service Licensee WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, 23a. Part1. Enter the disease, o complications that cause shock, or heart failure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 110 statio cance /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate has been signed by the aftending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 ☐ No 3 Probably 4 Unknown denression Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 - No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 20 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending To the rosp..... within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Naomi Registrar's Signature 31. Date filed (Month, Day, Year) State barkal Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Ma		epartment of F Certificate of I			giene Reg. No. 2	009	05368
		Decedent's Name (First, Middle, Last,)				2. Date of Dea	ath		3. Time of Death
Physicia /Medic		ROBERT HILL, JR.					Month FEB.	Day 14,	Year 2009	4:55 A M
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	-		inty of Death	
		GILCHRIST CENTER			BALTIMO					
Funeral Director		219-52-3030	₹M 2□F	(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da NOV. 3,	1948	9. Birth Cou	place (State or Foreign intry) MD
/land low at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location					10d. Inside City Limits
a-f sh	ctor	MD		BALTIMO	DRE					1 X Yes 2 □ No
th the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
ath wi		1909 E. BELVEDERE			21212			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 MYes 2 □ N If Yes, Give Year or Dates:		 Was Decedent of H If Yes, specify Cuba □Yes 2 No 	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, acify: BL	etc.
iin 72 hou r. n "natura Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+		lecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	during most of work	ing	16b. Kind o	f Business/Ir	ndustry
ed with ygiene ier tha t, tre	Com	12TH	College (1-40) 5+	' I	ABORER				ING/ST	FORAGE
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hould d Mer marke matic	으	ROBERT HILL, SR. 19a, Informant's Name/Relationship (Ty	no Print)	10h A	Mailing Address (Street	NANCY LI		or City or To	wn State 7	in Codo)
nd 2 s ulth an 27 is r rtrau		DAMON HALE/SON	pe. r mitj		411 MARBLE					,
s 1 ar of Hea item		20a. Method of Disposition			isposition (Name of crematory or other place					own State SON FOREST
Page nent c		1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			RISON FORES	ì			MILLS	
ermit. epartr nporta ny Inji		21. Signature of Funeral Service Licens	ee A	1	22. Name and Addre	ss of Facility WES	LEY CHA	VIS, J	R. FN	RL. HM.
<u>0</u> 0 = 60		Mesley	/han		2007-09	EASTERN A	VE., BA	LTIMOR	E, MD	21231
Dhysisian		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	the death. Do no						Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of)	- TIOI	2 ARCIT	617			days
Examiner		Sequentially list conditions	Intend	scient	rc card	housed	and	1800	re	43
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of)	:					0
execut	xar	that initiated events resulting in death) Last	Due to (or as a	consequence of)	:					
icate be executed physician and the burial-transit										
rtificate ng physi as the b	Nedical									
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d.	Date of delive	very Day Year
s that gned b	by Pi	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	ne underlying cause give	en in Part I.	23e. Did to	bacco use o	contribute to	the cause of death?
w require been sign	ted	cerebiovascula	Lousecs	e/CV	74		1 🗆 Y	es 2□N	o 3 Aro	bably 4 Unknown
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Physical direction	<u></u>	1 ☐ Yes 2 No P	lospital: 1 ☐ Inpatier 28a. Date of Injur	nt 2 ER/Outp		4 LI Nursing Ho	ome 5 Residence 128d. Describe h			ify) JOSPICE
ding Phy th. After thi funeral o	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year) Zob. Inji	ry Worl	Yes 2 □No	20d. Describe i	low injury oc	curred	
Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, p	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Nu n, State)	ımber or Rui	ral Route Number,
To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C			examination and/	death occurred at the til or investigation, in my c					
To the within 2 To the complet	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date sig	gned (Month,	Day, Year)
		Dondall	_ / S C	ulles	(no Print)	5643		02/	14/ 6	2009
1 4		30. Name and address of person who con Service Fault 31. Date filed (Month, Day, Year)	ner ND/ 5	255 W	.Towson	teur Bl	ud/Ba	elto.	MD ?	21204
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	barked					
Registra	ar	FFR 2 3 20	119 Done	as fil.	Mar ar ar ar					

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State of Maryland / Department of Health and Mental Hygieney 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month 5.45 A M **Physician** 200 1415 COC INDA I-EBRUNRY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore NOTHWEST PITA Randallstown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/11/1939 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🖺 F 69 Maryland 216-38-3832 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2K No Director Baltimore Randallstown MD 10g. Citizen of What Country? 10e. Street and Numbe 10f Zin Code USA 21133 3812 Brownhill Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces' 1 ∐Yes 2 ½ ∏ If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Her Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Evans Richard Mass Wheat ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3812 Brownhill Rd., Randallstown, MD 21133 Robert Hiscock/ Husband permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State South Carroll Crematory 2/18/09 Winfield, MD 4 Donation 5 Dother (Specify) e of Funeral Service Lic Burrand More & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. art 1. E for the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme vate Carse (Final disease or indition **Physician** DINGESTIVE HEART FAILURE disease andition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUC MRDMIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Justian State of Highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifiq Alamo D41410 Lepznary 200 10 JOGINDER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL MOLTA LAEST 31. Date filed (Month, Day, Year) 32. Registrar State FEB 2 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Mar State Registrar		Certificate of D		/lental Hyg	glene 2009	05370
	Physici: /Medic	an	1. Decedent's Name (First, Middle, Last)	İ	TLA		2. Date of Dear Month February	ary 19 20	
-	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 092-64-4145 7. Age	(In yrs. last birth	4b. City, Town, or Baltimore nday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 7,	4c. County of Death	thplace (State or Foreign unity) Berma
	ъ	.or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location Omery Villa	an			10d. Inside City Limits 1 Yes 2 □ No
	th with the A 23a or 28a- st be notifie	al Director	MD Montgomery 10e. Street and Number 9619 Marston Lane	Horreg	10f. Zip-Code 20886	<u>ye</u>	1	0g. Citizen of What Co	Luntry?
36	ırs after dea I", or items xaminer mu	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ★ No. If Yes, Give Year or Dates:		13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at eg.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+		Decedent's Usual Occupa (Give kind of work done a life. DO NOT use retired) Hairdresse	during most of wor.	king	16b. Kind of Business	•
land 21	should be filed with and Mental Hygiene. s marked other than umatic event, the M	To Be Co	12 17. Father's Name (First, Middle, Last) U Tha Hla		na i i di esse	18. Mother's Nar	ne (First, Middle, an Mya	Maiden Surname)	ue
, Maryland	1 and 2 shou Health and M em 27 is mar ether traumati		19a. Informant's Name/Relationship (Type. Print) Christine L. Hla / Wife		Mailing Address (Street a			y Village,	MD 20886
Baltimore,	permit. Pages 1: Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Ardent	Disposition (Name of y, crematory or other place Crematory	2/2	1/2009	Hanover,	MD
Ba	permi Depai Impoi any ir		21. Signature of Funeral Service Licensee Dorota Ma 23a. Part 1. Enter the disease, or complications that caused It shock, or heart failure. List only one cause on each line.	he death. Do no		P.O. B	ox 1413	remation So Baltimore, rest,	MD 21203 Approximate Interval Between
	Physician /Medical Examiner	er.	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a Sequentially list conditions, b.	Consequence of	myeloc	genou	s lec	ukemia	Onset and Death
8760,	icate be executed physician and is the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a d						
Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 2 □ Live birth 2 3 □ Tregnant at ti	E Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of de Month	elivery Day Year
rds, P.O.	quires that the signed by uld be detact	by	Part II. Other significant conditions contributing to death but	t not resulting in	n the underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute te	to the cause of death?
al Reco	The I	Completed		•				sy prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
of Vita	Physician: The this certificate eral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manger of Death 28a. Date of Injury		tpatient 3 DOA Other	er: 4 🗆 Nursing H	th (Check only on ome 5 Resid		cify)
Division of Vital Records,	or Attending after death. Director: After I in by the fune	Certification:	1 Natural 5 Pending (Month, Day 1 2 Accident investigation	<i>y</i> - At home, fan	njury Work			Street and Number or F	Rural Route Number,
_	e Hospital 124 hours e Funeral I	edical C	29a. Certifier (check only one) 1 Certifying Physician; To the best of 2 Medical Examiner: On the basis of and manner state	examination and					
3	To the I within 2 To the I comple	Me	29b. Signature and title of certifier T. Woreta, M.D.		29c. License	s number	-	29d. Date signed (Moni	1h, Day, Year) 9 2009
_			30. Name and address of person who completed cause of de		(Type, Print)	600	North Wo	Ife St, Baltim	ore, MD, 21287
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	s oignature					

DHMH 17 Rev 1/2001

ORIGINAL

Amend 29d per MD 8888 2/23/09 The State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health and Mental Hygiene 200 State of Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department / Departmen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02-17-2009 **Physician** Viviane Hioba 06;15 at /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Pay, Year) 6 4 9. Birthplace (State or Foreign Country)
Cameroon, Africa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 □ X 213-69-9946 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modon Event and be putfied an office. 1 Yes 2 No Takoma Park Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20912 U.S.A. 6733 New Hampshire Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specit Black þ 3 ☐ Widowed 4 🖾 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Lanudry Tech. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Monsing Mimbang Samuel Hioba 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clement Hioba/Brother 610 Concerto Ln. Silverspring, MD 20901 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Mem. Ceme. Waldorf,MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm. 21. Signature of Flineral Service-Licenses 10583 Middleport Ln White Plains, MD 20695 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the ruce after death.

Within 24 hours after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 296 271 signed (1009h, Day, Year) 29b. Signature and title of certifier 29c. License number KOUATCHOU, MI De063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

amend #7 Per Ana BD G888 2/26/09 Jh State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 6125A M **Physician** 09 Tyler Jacobs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square. Social Security Number timore 2009 If Under 24 Hrs. Hours , Min. 8. Date of Birth (Month, Day, Jan 30, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 10 Min. 1009 1 ₹ M 2 □ F Yrs Maryland Director infant Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh t be notified MD Baltimore Rosedale 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health, and Mental Hygiene. Important: If frem 27 is marked other than "natural" or the any injury or other traumatic every than "natural" or the process. 6711 Havenoak Road #C 21237 USA

Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Tyeisha Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4□Donation 5ĬOther(Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** He maturita /Médical Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes **2021** No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate has autopsy 1 Yes 20X No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: Af obtely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signarure and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2 2 RESCOUL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIJIOKE OFFOR 9000 FRANKLIN SQUARE Drive, Beltimure, mp 2/237 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar الممعطون ا

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day /Medical Robert Jackson February 6, 2009 3:40 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5605 S. Marwood Blvd #217
5. Social Security Numberunk | 6. Sex | 7. Ag Prince Geroge's Mar1boro If Under 24 Hrs. Upper 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday, If Under 1 Ye Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Director 68 Aug 31, 1940 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at MD Prince George's Director Upper Marlboro 1 ☐ Yes 2√☐ No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5605 S. Marwood Blvd #217 20772 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evanesconce. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) counselor employment office 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Harry Jackson Dorothy Slaney ပ္ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Jackson/brother 601 Hut-West Drive Flushing, MI 48433 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\overline{Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature Tryne 15 ryice bicensee Warde Virector Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriose Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-tran Due to (or as a consequence of): Box 68760, physician requires that the death certificate be Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months? Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown has been signed by e 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate ! 2 🗆 No 2 **- N** 1 🗆 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 □ es 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year, eted cause of death (Item 23a) (Type, Print) HOS 300/ 32. Registrar's Signatur State Registrar

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		for State Registrar		•	Certificate of		, ,	g. No.2 1 1 9	05374
D		1. Decedent's Name (First, Middle,	Last)	4			2. Date of Death		3. Time of Death
Physicia /Medic		DOUGLAS)	No.	DenKin	5	Month O2 /	Day Year 7 2009	4:15 PM
Examin	er	4a Facility Name (If not institution,		1	4b. City, Town, o	r Location of Death		4c. County of Death	,
		5. Social Security Number	5. Sex 7. Age	(In yrs. last birth	R DAL+	MORE 1 If Under 24 Hrs.	8. Date of Birth	O Divite	olean (Chata as Farrier
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Ment Ment arked aric e	70	Robert Jenkins				Queene	Elizabet	h Johnson	
2 showing the short of the shor		19a. Informant's Name/Relationshi			Mailing Address (Street				*
1 and Healt em 27 ther t		Lakisha M. Jenk 20a. Method of Disposition	ins / Wife		26 Fairbank			Maryland 2: Oc. Location - City or To	
ages ent of t: If it y or o		1 X Burial 2 ☐ Cremation 3			Pisposition (Name of crematory or other place			-	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminer must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Service Li		MD Vete	erans Cemet	ss of Facility		rownsville	
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Physician	1	Immediate Cause (Final disease or condition	Henra-	tic FA	1: Lure	1 CIRT	Phosi =	5	Onset and Death
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uted d ansit	Examiner	Sequentially list or differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence or,					
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leath certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deliver	ery Day Year
at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown	ine or dealir	S L Ottler (specify) _				
uires that signed to d be deta	by PI	Part II. Other significant condition	s contributing to death but	not resulting in the	ne underlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director the funeral director.	Medical	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner state	examination and/	death occurred at the tir or investigation, in my o	me, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s e and place, and due to	tated. the cause(s)
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IHTI		30. Name and address of person w	no completed cause of dea	ath (Item 23a) (Ty	/pe, Print)	· ·	0		
1		31. Date filed (Month, Day, Year)	32. Registrar	'e Signature	JONGR	2 encone	STEALY.	more MD	2201
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250 497483

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Chray 17th Year Dorothy Mae Jackson 630 AM 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Season's Hospico-Northwest Randallstown If Under 24 Hrs. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Min. 1 □ M 2 ▼ F Days Hours 214.50.000Z **Director** 09/18/1933 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

The should be a should be MD NIA Baltimore 1 Xves 2 □ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6823 Avenue USA Fairlawn 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 Married 1 ∐Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic NIA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mitchell Nut Alice Hall ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fairlawn Avenue Baltimore MD 21215 Naomi Jackson augnter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If It any injury or o once. 1 Burial 2 Cremation 3 Removal from State 02/23/09 Baltimore, MD Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Green 2 Tungal SVCS 8728 Liberty Road Randallstonin MD 21133 21. Signature of Funeral Service License lough 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su has cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Athorosciorotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if my, and it cause cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 12 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) SOFONS HOSPICE 6 Dother (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🕅 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avenue Surfe 203 Baltimore MD 2120 SWITCH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ELFRIEDE 14 46 AW KARPINSKI 02 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CROSS HOSPITAL If Under 24 Hrs. MONTGOMERY URR 9. Birthplace (State or Foreig Country) If Under 1 Year Months Days 8. Date of Birth (Month, Day Sept 22, 5. Social Security Number Age (In yrs. last birthday) **Funeral** Min. Months 1 □ M 2 🔽 F Hours 088 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director MONTGOMER WHENTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6090 USA 4011 HAJOOURA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EMPLOYED NINI NUN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISOO FOREST GLEN RD SS MO HOLY GROSS HOSPITAL 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5★Other (Specify) in state 21. Signature of Euneral Sovice Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 24 HRS STROKE BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner CEREBROVASCULAR TEGUN attending physician and for use as the burlal-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Day Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, þ FIBRILLATION 1 Nes 2 No 3 Probably 4 Unknown Completed OPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 □ DDA ٩ 1 Inpatient eral Director: After th filled in by the funeral 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

GEORGE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENGS

ACV 3929 F 32. Registrar's Signature

FERRARA

DR

SILVER SPRING MO

Bibi Aklei	na Karpanya	
09-01272	Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legible.
UNK UNK	State of Maryland / Department of Health and Mental H	ygiene 2009 0537
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
Medical Examiner	BIBI AKLEMA KARPAIYA	February 12, 2009 0757 11'S
(4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Laurel Regional Hospital Laurel	Prince George's
Funeral	5, Social Security Number 6, Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	Foreign
Director	214-33-1830	Oct. 16, 1974 Country) Guyana
	Usual Residence of Decedent	10d. Inside City Limits
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the Maryland to 28a-f show	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the Ma a or 28 tiffed	11325 Laurelwalk Drive 20708	U.S.A.
or items 13	11. Marital Status 1	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
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6 72 hours an "naturical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	Retail (Wal-Mart)
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Isultan Ali	
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Aldrin Karpaiya / spouse 1325 Laurelwalk Dri Laurel, Maryland 20	Rural Route Number, City or Town, State, Zip Code)
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Baltimore, permit, Pages I ar Department of Her Important: If ite	4 Donation 5 Other Specify: 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Donat a Son Funeral	Home, P.A.
The second second second	/ M00770 313 Talbott Avenu 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ac Eddies, see 1
Physician 'Medical	failure. List only one cause on each line.	Between Onset and Death
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	cause. Enter Underlying Cause (Disease or injury that initiated	
	events resulting in death) Last d.	
cian an	UNPENDED AMENDED	
the death certificate be executed by the attending physician and ched for use as the burial - tra	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery nancy Month Day Year
x 68 h certif tending use as	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
Bo re deat	1 Yes 2 No 9 V Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ires that the death certificate be executed signed by the attending physician and 1b detached for use as the burial - transit		1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been sig, page 2 should be		24a. Was an autopsy findings available prior to completion of cause of
tal Records, tian: The law requirements certificate has been sector, page 2 should		performed? death? 1 Yes 2 No 1 Yes 2 No
cian: TI certifica	25. Was case referred to medical	
F Vita Physici	1 V Yes 2 No	rsing Home 5 Residence 6 Other: 28d. Describe how injury occurred
n of Inding Ph	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending Pending 28c. Injury at Work? 1 Yes 2 ✔ No	Pedestrian struck by auto
VISIOR or Attend fler death Director: in by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Div pital or ours aff filled ir	determined (Specify) Major Road / Highway	Rt. 198 7 Russett Green East, Laurel, MD
		and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
To the within to the complex c	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	hy his o.C.M.E.	February 13, 2009
10	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
\		
Sta	EED 9 2 2000 A LANGE OF LANGE	

			For State of N State Registrar	Maryland / Dep <i>Ce</i>	ertificate of L		lental Hyg R	_{eg. No.} 2009	05378
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Dawn	Kemp			Feb.	17 2009	9:27 P. M
1	Examin		4a. Facility Name (If not institution, give street and number	er)		Location of Death		4c. County of Deat	
	₹		Kline Hospice House 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday	1	Airy If Under 24 Hrs.	8 Date of Birth	Freder	
	Funeral Director		216-70-9990 1□ M 2√ F	51 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, 9/26/I	957	thplace (State or Foreign ountry) MD
	70		Usual Residence of Decedent						10d. Inside City Limits
	arylar show	٦	10a. State 10b. County	10c. City, Town or L					1 ☐ Yes 2X No
	the M	Director	Maryland Carroll 10e. Street and Number	New w.	indsor		1	0g. Citizen of What Co	ountry?
	with Sa or		1520 Greenwood Church Ro	ī	21776			USA	
	ms 2	Funeral	11. Marital Status 12. Was Decede Armed Force		I. Was Decedent of H		ecify Yes or No-	14. Race - Ame Black, White	
õ	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examine Instat bunciffied at		1 ☐ Never Married 2 2 Married 1 ☐ Yes 2	No ON	1 □Yes 2 □No	Specify:	ritodii, otoly	Specify:	
2-003p	hours tural",	ed by	3 Widowed 4 Divorced Year or Date		sedent's Usual Occup	ation		16b. Kind of Business/	White
<u>-</u> C12	in 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	(Giv	re kind of work done of DO NOT use retired	during most of work	ing		,
717	d with giene er tha	Mo	Elementary/Secondary (0-12) College (1-40		ract Sales	Manager		Commercial	Flooring
and	be file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)					Maiden Surname)	
, Via	ould to marke narke	၉	Peter Colombo	40) 14:	"" A	Vonnie		- City or Town State	Zin Coda)
<u> </u>	d 2 sh th and 77 is n traun		19a. Informant's Name/Relationship (Type. Print) Hus Roland Kemp	sbana	o Greenwoo			r, City or Town, State, I New Windsor	_
<u>o</u>	f Heal f Heal tem 2		20a. Method of Disposition		position (Name of ematory or other place			20c. Location - City or	
aitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examine in ast be retified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)		ew Mem. Pa		/09	Sykesvi	lle, MD
a	rmit. spartn porta y fnju		21. Signa of Funeral Service Licensee		22. Name and Addres	ss of Facility		& Cromato	rv. PA
<u>n</u>	89 E 29		Xany of Cally		Burrier-Qu 1212 W. (leen rune)ld Liber	raı Home t y Roa c		1 Min 21784
	6.		23a. Part 1 Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	h line.	inter the mode of dyli	ig, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
e de la	Physician /Medical		Imm diate Cause (Final disease or condition resulting in death)	416/17/17	LUNG	ANCE	12		
	Examiner		Due to (or	as a consequence of):	TAKTA	505			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):	1713111				
	nd A land	Examiner	that initiated events C.						
Ď,	be exectan a	E	resulting in death) Last Due to (or	as a consequence of):					
09/89	eath certificate be executed attending physician and for use as the burial-transit	edical	d						
Box	n certif		IF FEMALE: 23c. If yes, outco					23d. Date of de	livery
	0 0 0	Physician/M	1 Yes 2 No 9 Unknow	nt at time of death 5	B ☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		Month	Day Year
л. О	ires that the de signed by the be detached f	Phys	9 LJ Unknown		undorlying muso gly	on in Part I	23e Did to	bacco use contribute to	o the cause of death?
Š,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to deat	in but not resulting in the	underlying cause giv	en in Fait i.	1 □ Ye		robably 4 Unknown
ecords,	v requir	Completed					24a. Was a	an 24h Were a	utopsy findings available
ĕ	sician: The law certificate has tirector, page 2 s	dmc					autops perfori	sy prior to death?	completion of cause of
Vital	an; T tificat tor, pe	Be Co	25. Was case referred to medical			26. Place of Deat		2 Ho 1 LYes	s 2 No
	nysici nis cer direc		examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inp	atient 2 ER/Outpati	ient 3 □ DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resid	ence 6 Other (Spe	acity) HOSPICE
Division of	Attending Physician: r death. ector: After this certific by the funeral director,	on:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of (Month,	Injury 28b. Time <i>Day, Year)</i> Injury	/ Worl		28d. Describe he	ow injury occurred	
<u> </u>	ttendi leath. tor: A the fu	icati	2 Accident investigation	Injury At home form		Yes 2 □No	29f Location (C	treet and Number or R	lum I Pouto Number
≥	I or All after c Direc	Certification: To	4 Homicide determined building	Injury - At home, farm, s , etc. <i>(Specify)</i>	street, lactory, office		City or Tow		urar noute ivaniber,
_	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier 1 Certifying Physician: To the base (Check only 2 Medical Examiner: On the base						
	the H hin 24 the F mplete	Medical	one) and manne		29c. Licens			29d. Date signed (Moni	
	८ ⊵ ८ ፩		29b. Signature and title of certifier	١	\\ \mathread \ma	0677	54	To L 18	2009
,	15		30. Name and address of person who completed cause	of death (Item 23a) (Type	e, Print)	1	1.	100,10	, 2000,
			CRISTINA TRIITCE	2 MM 2	401 W	15KLVED	eren	VE, BALTI	MOREMA
	Sta Registr		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signatur					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 05379Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 8:45 PM Tie Ke 2009 /Medical 4h, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** B2 Himas NIA City Hospits Hmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 D Months Days Hours Min. 76 Yrs. -40-377 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the the disaller event at the control of the contr Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No ģ Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Troomer rouner torse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Kenneu vak VIQ 1homas 5101 GWYNN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 23,2009 22. Name and Addres of Facility 21. Signatore of Funeral Service Lice well 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Mitstite **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to finite distance. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cruce. Physician/Medical Examiner Due to (or as a sone equence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the a detached 1 TYPS 2 No 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 **M**No 21 No 1 □Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Mayner of Death 28b. Time of Injury at Work? 28c. 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifile 0006329 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

TU

32. Registrar's Signature

31. Date filed (Months Day, Year)

			1 - For State Registrar	State of Maryl	and / Depa <i>Cer</i>	artment of Hea tificate of De	alth and M eath		ne No. 2009	05380
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		Lo	wery	1	2. Date of Death Month	Day Year	3. Time of Death 1 0856 4 M
	Examir		4a. Facility Name (If not institution, give s The Johns Hopkins Ho	spital		4b. City, Town, or Loc Baltimore C	cation of Death		4c. County of Deat	
	Funeral Director		230-00-0343	M 2 □ F 7. Age (In)	yrs. last birthday) Yrs.		Under 24 Hrs. lours Min,	8. Date of Birth (Month, Day, Yea Aug 27,]	ar) Co	thplace (State or Foreign untry) unk
	-f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County MD	100	. City, Town or Lo					10d. Inside City Limits 1√√ Yes 2 □ No
1	3a or 28a t be notifi	al Director	10e. Street and Number 2003 Bank Street			10f. Zip-Code 21231		10g.	Citizen of What Co	untry?
036	urs aner deau II", or items 2 xaminer mus	by Funeral		2. Was Decedent Ever if Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispa f Yes, specify Cuban, M	inic Origin? (Spec	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	e, etc.
21215-0036	ges I and 2 should be filled within 7.2 hours after death with the maryland the filled and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) unk u		(Give	dent's Usual Occupatio kind of work done durir DO NOT use retired)	n ng most of workin	unk 168	b. Kind of Business	Industry unk
Maryland 2	should be lifed and Mental Hygi s marked other umatic event, ti	To Be C	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Typ.		10h Meili	unk 18	Esthe	(First, Middle, Mai	у	
	Health and employers the Health and em 27 is mother traums		The Johns Hopkin	s Hospital	600	N. Wolfe S	treet Ba	ltimore,	MD 2128	7
-	permit. rages Department of I Important: If its any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 X Other (Specify)	emoval from State in state		natory or other place)	f 		c. Location - City or	
Ba	Depa Impo any it		21. Signature of Funeral Sarvice Licenses Ronald	nei	Ba	Name and Address of ate Anatom	D 21201	<u> </u>		
	hysician /Medical		sh ck, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or a) a con	1	er the mode of dying, s	uch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
8760,	physician and as the burial-transit	edical Examiner	Sequentially list conditions, library learning in clair cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		tololus Secumbe di	e preu	monice			2 days
Hecords, P.O. Box 68	the attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	been signed by the a should be detached	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause given	in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
		Completed						24a. Was an autopsy performed 1 Yes 2	? prior to o	topsy findings available completion of cause of
VIÇ	certificate irector, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ■ No	ospital: 1 npatient 2	P ☐ ER/Outpatient	- Other	Place of Death (
to a	h. After this funeral d	일	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at		e 5 □ Hesidence 3d. Describe how in	6 ☐ Other (Spec	ify)
	eath. or: Afte the fun	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	M 1 ☐ Yes	2 🗌 No			
DIVIS	ं र ठ ं	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Spe	ecify)			City or Town, Sta	•	
the Hosni	within 24 hours after To the Funeral Directory completely filled in the	Medical	one) 2 Medical Examin	cian: To the best of my ler: On the basis of exame and manner stated.	knowledge, death ination and/or inv	estigation, in my opinio	on, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
ام م	To To	Σ	29b. Signature and title of certifier			29c. License nun			Date signed (Month	, Day, Year)
		}	30. Name and address of person who col	inpleted cause of death (Item 23a) (Type,	Print)	200	tes	may6,	2007
				ANG.		·	600 N	orth Wolfe	St, Baltimo	re, MD, 21287
	Sta	7.6	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05381 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CLAUDE HENRY LAWSON ebruari /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner TOUR 4/and GIFTERUL exmore Spital If Under 1 Year | If Under 24 Hrs. 5. Social Separity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 X M 2 □ F Hours Director 58 216-54-1392 NOV. 4, 1950 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 427 OXFORD CT 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2**X** No 5 Specify: BLACK 1 ☐ Yes 2 ☒ No ģ Specify 3 Widowed 4 Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH LABORER WAREHOUSE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other i any Injury or other traumatic event, <u>I</u>II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ CLARENCE LAWSON HAZEL CROOM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BIS. LARRY LAWSON, SR./BROTHER 4113 E. LOMBARD ST., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State 5712 O DONNELL ST. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. CARMEL 02/28/2009 BALTIMORE, MD 21224 21. Signature of Funeral Service Licens 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the diseasock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician Physician/Medical as attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate rmed? 2 No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

> State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month; Day,

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Ma	ryland /	Depar Cert	tment of F ificate of I	lealth and M D <i>eath</i>	ental Hyوا ۱	giene Reg. No. 2 (09	05382
	Physicia	an l	Decedent's Name (First, Middle, Las	•					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Margar	et Est			Location of Death	Februar	4c. County		9:35 P ^M
	Examin	er	Laurel Regional F				Laurel			Princ		orge
	Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age	e (In yrs. last I 87	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 12,	(, Year)	9. Birthp Coun Mar	lace (State or Foreign ltry) yland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince	George	10c. City, To		ation				11	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a e rotii	Funeral Director	10e. Street and Number	scorge	20020		10f. Zip Code			10g. Citizen of \	What Coun	ntry?
	ath wi	sral	310 2nd Street	12. Was Decedent E	Tues in LLC	12 W	20707	lienanic Origin? (Sp	acify Ves or No.	U.S.A.	e - Americ	an Indian.
030	be filed within 72 hours after death with the Maryland Ital Hygiene. dother than "natural", or items 23a or 28a-f show event, it a Medical Examirat must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Yes, specify Cub ☐Yes 2 【 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, 6	etc.
212	filed within 72 ho Hygiene. other than "natur ent, I'm Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	(Give ki life. Di		oation during most of work d)	sing	16b. Kind of B		dustry
12	e filed w al Hygiel other tl vent, th	S	12 17. Father's Name (First, Middle, Last)			Homem	aker	18. Mother's Nam	e (First, Middle,			
yland	lld be f fental I rked of tic eve	To Be	Amos Dwight Tutt	Le				Anastas	ia McInt	cyre		
_	shound N	-	19a. Informant's Name/Relationship		1	9b. Mailing	Address (Street	and Number or Rui	ral Route Numbe	er, City or Town	, State, Zip	Code)
, Mar	s 1 and 2 should f Health and Mer tem 27 Is marke other traumatic		Alfred J. LePore	/spouse				et, Laure	l, Mary	Land 207		State
ore O	iges 1 nt of H : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			ition (Name of atory or other pla			Odentor	-	_
Baltimore,	permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau		4 □ Donation 5 □ Other (Specify 21. Signatury o Fungral Service Icen		W. A	22	Name and Addre	cory Feb	- 22		i, Pia.	Tyrana
ñ	Dep mp any		All All		M0077	3 31	3 Talbot	Funeral L	aurel, N	Maryland	207	07-4389
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only	plications that caused one cause on each lir	the death. D	o not ente	r the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause Fin 1 disease or condition resulting in death)	a. Severe	COPD /	Emph	ysema					
	/Medical Examiner			Due to (or as	a consequent	ce of):						
9	7 7	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	ce of):						
Y	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2 0000000000	co of:						<u> </u>
8760,0	icate be executed physician and the burial-transit	dical E	(Joseph January 2001)	d	a consequent							
O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3 🗌	Ectopic pregnan Other (specify)	су			ate of deliver	ery Day Year
σ.	that the ned by detac		Part II. Other significant conditions of	ontributing to death b	ut not resultin	g in the un	derlying cause gi	ven in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
rds,	w requires to been signed should be	ed by							1 🗆 '	Yes 2 □ No	3☐ Prol	bably 4 🛚 Unknown
Seco	2 % C	Completed							24a. Was autoj		Were auto prior to co death?	opsy findings available ompletion of cause of
a			25. Was case referred to medical	1				26. Place of Dea	1 □Yes	2 X No	1 □Yes	2 ∑ No
=	S S in	o Be	examiner? 1 Yes 2 No	Hospital: 1 🔀 Inpatio	ent 2 ER	/Outpatient	t 3 □ DOA Ot	nor:	lome 5 ☐ Resi		her (Speci	fy)
Division of Vital Record	nding Phy ath. r: After thi e funeral	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	iry iy, Year) 28	b. Time of Injury	28c. înju Wo M 1	iryat rk?]Yes 2 □ No	28d. Describe	how injury occu	rred	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: T	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, et	c. (Specify)				City or To	wn, State)		al Route Number,
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical	29a. Certifier 1 X Certifying Pl (Check only 2 Medical Example)	nysician: To the best miner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as , and due t	stated. to the cause(s)
	Fo the within to the complex c	Med	29b. Signature and title of codifier	A	atou.		29c. Licer	se number		29d. Date sign	ed (Month,	Day, Year)
			1///	can \			D6	4874		Februa	ry 20	, 2009
	10	-	30. Name and addless of person who					Dles ve	+0 200	Columb	ia M	מוחור חו
	St.	ate	Shahab Bavani, M 31. Date filed (Month, Day, Year)		24 Litt rar's Signature		ituxent	Pkwy, Sui	Le 200,	COTUIND.	ra, M	D 21044
	Regist		EED 0 0 0000		1	1	1					
DH	IMH 17 Rev 1/3	2001	FEB 2 3 2009	properties	10. 1	ORIG	ΙΝΙΔΙ					
						UNIC	111 V/\la					

			State of Maryland / Department of Health and Mental Hygiene Cortificate of Death	03
			Registrar Certificate of Death Reg. No. 2007	00
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1/5	eath M
- mary	/Medic Examin		4a. Facility Name (If not/institution, give street and number) 4b. City, Town, or Logation of Death 4c. County of Death	
	Funeral	-	5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or	Foreign
	Director		221-24-1300 1 M 20 F 81 Yrs. Months Days Hours Min. (Month, Day, Year) 5 Carrolina	
	/land low		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at once.	ector	Md. Baltiyore 1X Yes 2	≧□No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	death ms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	or ite	by Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify:	
21215-0036	2 hours	ted b	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
215	thin 73	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	
d 21	filed w Hygier ther th	CO	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	uld be f Aental rked o	To Be	Council Hines	
lary	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, ⊠	Health		David M. Hamm Son 17191 Kavenswood Pl. Kancho Cucamonga, Ca.	11761
altimore,	ages 1		20a. Method of Disposition 1. Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Mathod of Disposition 20c. Location - City or Town, State 20c. Location - City or Town, State	1
altir	permit. P Departme Importan any Injur.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AUGhn C. Green Funeral Service Company of Service Service Company of Service	I-V.
Ä	permi Depal Impor any Ir		Vaughn C. Alene 8728 Liberty Rd. Francialistown, Md. 211	33
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cause (Final Cause of Each Ca	
4	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	
	Examiner	_	Rohal Feilure	
112.	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
0,0	cate be executed physician and the burial-transit		that initiated events resulting in death) Last Due to (or as a consequence of):	
,0928	ficate be executed physician and s the burial-transit	dical	d. Voigsetes	
9 xc	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
P.O. Box	e death he atte ed for	sicia	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	ar
	res that the de signed by the a I be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	ath?
Division of Vital Records,	Attending Physician: The law requires that the death certificath. r death. ector: After this certificate has been signed by the attending iby the funeral director, page 2 should be detached for use as by the funeral director, page 2.	Completed by Physician/Me	1 Yes 2 No 3 Probably 4 Yun	
eco	e law requir has been s ge 2 should I	plete	24a. Was an autopsy prior to completion of cau	ailable
a B	r: The icate h		performed? death? 1 □ Yes 1 □ No 1 □ Yes 2 □ No	ise oi
Z:	siciar certif rector	Be	25. Was case referred to medical examiner? 1 Tyes 2 No. Other: A Disputation of Death (Check only one) Hospital: 1 Impatient 2 TER/Outpatient	
ot	g Physical dispersal di	n: To	1	
sior	tendin eath. or: Aff the fur	catio	2 Accident investigation M 1 Yes 2 No	
Σįχ	or Att	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)	∍ <i>r</i> ,
_	ospital hours uneral ly filled		29a. Certifier (Check only (C	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) and manner stated.	
	5 × × × ×	_	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	7
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven J. L. Greet V. 15 Worthwest Hospitals	1
	10		Steller J. Schwert, 45 Northwest Hospital	
	Sta Registr		FEB 2 0 2009 Liver A. James	

			For State Registrar	State of M	laryland		rtment of F		nd Mental Hy	giene Reg. No. 20	109	05384
. 20	Physici /Medic		1. Decedent's Name (First, Middle, May lek	Malek	kma	r Z 1	ban		2. Date of De Month		Year	3. Time of Death
1	Examin Funeral		4a. Facility Name (If not institution, g	avitani	405p1 ge (In yrs. Ia	st birthday)	4b. City, Town, o Baut If Under 1 Year Months Days	The Location of The Location o	4 Hrs. 8. Date of Bir	4c. County, BOL7 th th, Year) 18	mo	re City ace (State or Foreign ry) Iran
	Director		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation		mai 27	, 1910	10	IL all
	the Mary 28a-f sho notifled a	Director	MD Baltim	ore	Pa	rkvil	Le 10f. Zip Code			10g. Citizen of V		1 ☐ Yes 2√☐ No
	s 23a or	ral Di	8710 EMGE Road					21234			USA	
5-0036	72 hours after death with the Maryland inatural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates:	?] No		Vas Decedent of H f Yes, specify Cuba I □Yes 2∰ No	lispanic Origi an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		e - America k, White, e y wh:	
1215-0	be filed within 72 hours after death with the Marylar Ital Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4or	5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired army off	during most (d)	of working	16b. Kind of Bu	usiness/Indu	•
lang z	ild be filed lental Hygi ked other iic event, tl	To Be Co	17. Father's Name (First, Middle, La				unk		's Name (First, Middle	, Maiden Surnam		unk
, mary	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship Armin Malek/son	(Type. Print)					or Rural Route Numb			Code)
more,	nit. Pages 1 a artment of He ortant: If Item injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 8 🖾 Other (Spe	□Removal from State	e ce	ace of Dispo metery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or Tow	vn, State
Dalt	permit. Departr Importa any inji		21. Signature of Funeral Service Lic	ensee Wade, Dir	eetor		Name and Addre ate Anat lltimore,		pard 655 W.	Baltimo	ore Si	treet
ì	Physician /Medical		2 a. Part . Enter the dise , e, or co sho , or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aa.	147-0	Do not ent			eardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	J.	Sequentially list conditions, if any, leading to immediate	b S.e	s a conseque	5	f:=		_			5 days
3/60,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	NOV s a conseque	TV ence of):	act In	fec.	tron		5	5 days
O. Box 68	aath certifii attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy	y		23d. Date Mor	e of deliven	y Day Year
ecords, P	w requires that the de been signed by the a should be detached	by	Part II. Other significant condition:	contributing to death	but not result	ting in the ur	nderlying cause giv	ren in Part I.	euha 10	obacco use contr Yes 2 100		e cause of death?
r	The la	Completed	Liver cin	chosis				·	24a. Was auto perfo 1 Yes	psy prmed?	prior to com leath?	sy findings available pletion of cause of
r vital	G ≅. ~	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	tient 2 E	R/Outpatien	t 3□ DOA Oth	107	of Death <i>(Check only o</i> sing Home 5 ☐ Resi		er (Specify)	
Vision o	Attending Physician: or death. ector: After this certification by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D	jury Jay Year)	28b. Time of Injury	28c. Injur Wor M 1 □		28d. Describe	how injury occurr		
DIVIS	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 28e. Place of in building, e	etc. (Specify)		eet, factory, office		City or To			
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physiclan: To the best caminer: On the basis and manners	of examination	fledge, death on and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deatl	I place, and due to the h occurred at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ted. the cause(s)
	Vith Vith Co.	Σ	29b. Signature and title of certifier	Pach			29c. Licens	e number	715	29d. Date signed	(Month, D	08
			30. Name and address of person w	completed cause of	death (Item 2	23a) (Type,		en Bli	vd, Balt	imore i	MD:	21239
1	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 3 2009	32. Regist	trar's Signatu	re	1					

09-01537 David G. Martinez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 05385

			- For State		Certificate	of Death			Reg. No.	2009 0330
	Physicia	an/	Decedent's Name (First, Middle,Las	st)				2. Date of Do Month	Day Ye	3. Time of Death
Med	lical Exami	ner	DAVID G. MARTI	NEZ				Februar	y 21, 2009	1341 1118
			4a. Facility Name (if not institution, given 1605 Orlando Road	e street and number)		4b. City, Town, Parkville	or Location of	f Death	4c. County Baltimo	ore County
		-	5. Social Security Number 6. S	ev 7 Age (In	yrs. last birthday) If Under 1 Ye	ear If Under	24Hrs. 8. Date of	Birth (MM/DD/YYY	Y) 9, Birthplace (State or
	Funeral Director			M 2 F			ays Hours	Min. 5/7/		Foreign Country) MD
		-	Usual Residence of Decedent							,
	any		10a. State 10b. County	The state of the s	City, Town or Lo					10d. Inside City Limits
	nd show	٦	MD BALTI	MORE	PARK	VILLE				1 Yes 2 X No
1	faryland 28a-f show I at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?
1	th the Maryland 23a or 28a-f sho notified at once.		1605 ORLANDO ROA	D		2.	1234		USA	A
3	with ns 23 be no	ala	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.			in? (Specify Yes or Puerto Rican, etc.)		ce - American Indian, Black, ite, etc.
	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Marrie	1 Yes 2 X	No					LUITOE
	after	ρ		d If Yes, Give Year or Dates:	i	Yes 2 X		and of work done		WHITE Business/Industry
	hour: 'natu		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	durir	ng most of working I	ife. DO NOT	use retired) .		ARD AUTO PARTS
	36 nin 72 E. Ifhan dical	Completed	11TH GRADE	conogo (, Toro-,	DEL	IVERY SEF	RVICE			
	5-0036 led within 7 Hygiene. other than the Medica	녌	17. Father's Name (First, Middle, Las	t)			18.Mother	s Name (First, Middl	e, Maiden Surnam	1e)
	215 be file ntal H iked o	Be (RALPH MARTINEZ					OTHY CERN		
	2121 ould be fi d Mental s marked lic event,	2	19a. Informant's Name/Relationship (**	19b. Ma	ailing Address (St	reet and Num	ber or Rural Route	Number, City or To	own, State, Zip Code)
	MD d 2 shc lth and n 27 is		DENNIS MARTINEZ/	BROTHER_				L RD. NO.		, MD 21236 n - City or Town, State
	nore, MD 21215-0036 siges I and 2 should be filed within 72 hours after not of Health and Mental Hygiene. 4: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 X Cremation 3		crematory of	sposition (Name of or other place)				
	Page nent o		4 Donation 5 Other Specif	v:						NSVILLE, MD
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other transmatic event, the Med		21. Signature of Funeral Service Lice	MOC	~ .,	22. Name and Addr				ERAL HOME, P.A.
			23a Pat L Enter the disease, or com	polications that caused the	death Do not en	8521 LOCH	H RAVEI	N BLVD.	TOWSON, I	MD 21286 neart Approximate Interval
	Physician /Medical	f	failure. List only one cause on e	each line. Hypertensiv						Between Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque		Ovascula	i dise	ase		
•			Sequentially list conditions,	o						
		le l	if any, leading to immediate	Due to (or as a conseque	ence of):					
	40	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
	outed nd ransit		CVC/Ito Tooding III Godiny Zadi	d						
	760, icate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED 23a,	PII,27,	perME, g	889 3/	3/09 TT		
	760, icate be physicate burthe bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	f pregnancy		o		23d. Date Month	of delivery Day Year
	certificanting	ä	past 12 months?	1 Live birth Pregnant at time		Fetal death Other (Specify)	3 Ectopii	c pregnancy	Month	Day Year
	Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknow		5	Other (Specify)				
	Aecords, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for t	ᆔ	Part II. Other significant conditions	s contributing to death bu	t not resulting in	the underlying caus	se given in Pa			ntribute to the cause of death?
	res the	d by	Chronic alcoho	lism						3 Probably 4 Unknown
	rds requi been hould	Completed						24a. W	/as an 24b utopsy	 Were autopsy findings available prior to completion of cause of
	e law te has ge 2 s	M M							erformed? es 2 No	death? 1 ✓ Yes 2 No
	FR III. The triffical or, pa	ပ္ကို	25. Was case referred to medical			26.Pl	ace of Death	(Check only one)		Incased Supremi
	Vita ysicia his ce direct	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	atient 3 DOA	Other ₄	Nursing Home 5	Residence 6	Other: Scene
	Division of Vital Records, P.O. Box 68: pital or Attending Physician: The law requires that the death certificate has the death. The law requires that the death certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as:	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tim	* * 1 =	Injury at Worl		ibe how injury occ	urred
	ion tendi eath. tor: /	aţi	1 X Natural 5 Pending 2 Accident Investiga			1'_	Yes 2			
	IVIS or At after d Direc	ti	3 Suicide 6 Could no	ot be 28e. Place of Injury	- At home, farm,	street, factory, office	ce building, e		on (Street and Nur n, State)	mber or Rural Route Number, City
	Divis Hospital or A 24 hours after Funeral Dire stely filled in b	Certification:	4 Homicide determine 29a. Certifier	1-1-1-1-1				_		
	e 2 4 E	edical	(Check only one) 2 ✓ Medical Examin	ician: To the best of my kr ier:On the basis of examin	iowledge, death ation and/or inve	occurred at the time stigation, in my opio	e, date and pl nion, death o	ace, and due to the occurred at the time, o	cause(s) and mani late and place, an	ner as stated. id due to the cause(s)
	To the I within 2 To the I complete	Med	29b. Signature and title of certifier	and manner stated.			ense number			igned (Month, Day, Year)
4	.6		May - A	(1/ 00		0.	.C.M.E.		February	y 22, 2009
4			30. Name and address of person wh	o completed cause of deat	h (Item 23a)					
				Assistant Medical Ex	aminer 11	11 Penn Street	, Baltimore	e, MD 21201		
			31. Date filed (Month, Day, Year)	32. Registrar's		backer				
	Regis	trar	FEB 2 3 20	100 Census	19. 14	Tarre				

			1 For State Registrar	State of Marylan	d / Depa		lealth and I	Mental Hyg	iene 2009	05386	
	Physic /Medi Examii	ical	1. Decedent's Name (First, Middle, Las 1. Decedent's Name (First, Middle, Las 4a. Facility Name (If not institution, give Blue Point Nursing Hom	street and number)	107	Ha	S r Location of Death	2. Date of Dea	th Day 2 Sea 4 4c. County of Dea	3. Time of Death 3. 40 A M	
	Funeral Director		212 32 0)03	7. Age (In yrs. I	• •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02-14-19	9. Bir	thplace (State or Foreign ountry) MD	
	dearn with the Maryland me 23a or 28e-f ehow trivial be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A		, Town or Lo	ocation				10d. Inside City Limits 1 Yes 2 □ No	
	3a or 28	i Direc	10e. Street and Number 3502 Woodbrook Ave			10f. Zip Code 21217		1	0g. Citizen of What Co	ountry?	
		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2X No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify		
2000	within 72 nours after one. ene. than "natural", or its ne Medical Exertine	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 8th	ucation fe completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of worl i)		16b. Kind of Business Baltimore Sci	/Industry	
2	z snould be Illed and Mental Hygis is marked other sumatic event, ii	To Be Co	17. Father's Name (First, Middle, Last) John A. McCoy				18. Mother's Nam	Maiden Sumame)	1001 System		
ĵ	1 end 2 sho Health and I em 27 is ma ther trauma		19a. Informant's Name/Relationship (7) Dorothea Goodman/Dough 20a. Method of Disposition	ter	3502 Wo	oodbrook Ave	e Baltimore	, MD 21217	, City or Town, State, . 20c. Location - City or		
	rtmer rtant		1	Mt.	. Zion	sition (Name of matory or other place 2. Name and Addres	02-24-	2009	Baltimore, M		
	nysician /Medical		23a. Part1. Enler the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line. a	. Do not ent	os N. Gilmon				Approximate Inlerval Between Onset and Death	
, So	e be executed sicien and e burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Use to (or as a consequence. — Due to (or as a consequence).							
	ine raw requires traine destincer inical site has been signed by the ettending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery D <i>a</i> y Year	
	n signed b	₽	Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact 1 Yes						co use contribute to the cause of death?	
	within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed	Dialota reliter 24a. Was ar perform perform 1 Yes 2						y prior to	utopsy findings available completion of cause of	
	this certil	To Be	1 165 2 100		ER/Outpatien		er: 4 Nursing Ho		ence 6 □Other (Spe	cify)	
	eath. or: After the funer	cation	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred		
	within the property of weathing rips control of the Fathous eller death. To the Fathorel Director. After this certification of the fathorel director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, elc. (Specify	·)			City or Town			
:	thin 24 ho the Fune mpletely fa	Medicai	29a. Certifier (Check only one) Secrifying Phy □ Medical Exami 29b. Signature and tille of certifier	sician: To the best of my knowner: On the basis of examinational manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	oinion, death occur	red at the time, da	ate and place, and due	to the cause(s)	
1	8 H 8		House	23.66	Jan H	10 1	2(6	80	9d. Date signed (Mont.	2009	
	7		30. Name and address of person who co	ARK HEV	6H	Print) TS A	اورك ر و	- MA	MAJKE	D 5/5/	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure &	. 4.1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month James Meinecke Sr. February 2009 11:14 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, Year) December 7, 1925 1 □XM 2 □ F 219-10-3443 83 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Overlea 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Clayton Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 TXNo Specify. 3 ₺ Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 years Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Meinecke Frances Zacharda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Janet E. Cook Daughter 5916 Clayton Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other r 20c. Location - City or Town, State February Nation | 2 □ Cremation | 3 □ Removal from State Sacred Heart of Mary Cem. Dundalk, Maryland 24, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Pa 1. Enter the dise shock, or heart failur. or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final NEUMONIA reek disease or condition resulting in death) Due to for as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown gs available of cause of

Physician /Medical Examiner Examir Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

show

r than "natural", or items 23a or 28a-f shov

within 72 hours after

12 should be filed within 7 h and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

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Meinecke, James Division of Vital Director

Funeral

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e Hospital or Attending P 124 hours after death. e Funeral Director; After t letely filled in by the funera

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Completed

Certification: To

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									24a. Was an autopsy performed2 1 □Yes 2 □ N	prior to death?	utopsy findings ava completion of caus
Was case referr	ed to medical					26.	Place of De	ath (Cf	heck only one)		
examiner? 1 ☐ Yes 2 🗗	40	Hospital: Other:							6 ☑Other (Spe	to to see	
Manner of Death I Natural 2 Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	, , ,	28c	. Injury at Work? 1 □ Yes		_	8d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined						28f. I	Location (Street a City or Town, Sta	and Number or Ru te)	ural Route Number	
a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	imer: Or	To the best of my keep the basis of examination of manner stated.	nowledge, death occination and/or investi	curred at gation, in	the time, d	ate and plac n, death occ	e, and curred a	due to the cause t the time, date a	(s) and manner a nd place, and due	s stated. to the cause(s)

29b. Signature and til

29d. Date signed (Month, Day, Year) Fe Gru Any 20, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles St. Balta Md 20204 6701 N-GBMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

within 24 hours a To the Funeral C

completely

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February **Physician** ์วี9**,** 200่9ื่ 6:00 May РМ Manuel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Essex

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nav 1, 1914 Baltimore Riverview Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 94 219-10-7646 Yrs Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 271s marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Examinating the notified at 1 ☐ Yes 2 No Dundalk Baltimore Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1728 Searles Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event. The Medical Exerci 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Virginia Higgins Earl Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Granddaughter 106 Perry Avenue, Auburndale, FL. 33823 Linda Walker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 21, 2009 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21 Signature Vineral Service Litre 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Parl 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10-12 lik Physician disease or condition resulting in death) /Medical Due to (or as a cons - uence of): Examiner clea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner un conorm physician and s the burial-transit that initiated events resulting in death) Last The law requires that the death certificate be exect Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year lor Month Day in the past 12 months? 5 Other (specify) signed by the aid ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Diractor: After this certification by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Mursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-38754. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEAM . 70 9 . E ASTERN BLVD. MD-21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Moore 07:50a^M 2009 Barbara Joyce 02 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Hospice 8. Date of Birth (Month, Day, 12 14 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Year) Hours Days 1 □ M 2 ▼ F Months 12 MD 63 214-44-9443 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ▼□Yes 2□No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code U.S.A. 21217 1906 Harlem Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 🛛 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) House Home Maker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mable Williams Melvin Ray Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1906 Harlem Ave, Baltimore, Md 21217 Andrew Moore Sr.-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 3/2/09 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licens 21215 4300 Wabash Ave, Baltimore, Md 23 Prt1. Enlight he disease, or complications becaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a construence of): RENAL MONTHS disease or condition resulting in death) DIABETES 4EARS Sequentially list conditions, if any, leading to infine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GANGRENE RIGHT HEEL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown VASCULAR DISEASS 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician: hours after death. filled in by

Physician

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Director

28a-f show

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2 should be filed within 72 and Mental Hygiene. is marked other than "na

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Department of Health ar Important: If Item 27 is any Injury or other trau

Physician

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Pages 1

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Injury or other traumatic event, the Medical Eventine quet be notified at

Physician/Medical Examiner 2 Completed Be (Certification: To 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D64395

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) FEBRUARY 21, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6565 N CHARLES ST. BUTE 209 BALTIMONE, MO 21204 DOBERMAN, MD 31. Date filed (Month Day, Year).

State Registrar

Medical



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09-014	164	
Judith	Martin	-EI

dith Martin -El		State of Maryland /	Department of Certificate of		d Mental H		g. No. 201	09 0539
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) Judith Johnson	Bey	Martir	n-E1	2. Date of Death Month February 1	h	3. Time of Death 0934 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center	4	b. City, Town, or Baltimore	Location of Death		4c. County of De	ath
Funeral Director		217-56-6767 1_M 2XF	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days		_	For	Birthplace (State or eign Country) MD
w any		Usual Residence of Decedent 10a. State 10b. County	Ioc. City, Town or Location					10d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	MD NA 10e. Street and Number	Balti	10f. Zip Code	21225	10	og. Citizen of What Co	•
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2 hours after dea "natural", or it Examiner mus	þ	Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education (Specify only highest grade comp		Yes 2 X No	specify:	work done	Specify:	Black
	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	+) during mo		DO NOT use ret		7.5	f Maryland
21215-0036 hould be filed within 7 nd Montal Hygiene. is marked other than tire event, the Medical	Be Cor	17. Father's Name (First, Middle, Last) James Johnson			18.Mother's Name Annie	(First, Middle, M. M. Gil.		
MD 21 start and Mo stricts and Mo stricts and aumatic ev	T ₀	19a. Informant's Name/Relationship (Type, Print) Alfred Summerville—Son	3518	Woodla	and Ave	, Balt:	imore, M	d 21215
Balfimore, MD 21215-0036 pernit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Importune: If it is 37 is marked other than injury or other unaumatic event, the Medica		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of Disposi crematory or oth Holly H	er place)		7/09	20c. Location - City Middle	River, Md
Physician Physician Physician		21. Agnature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the	_ ¥3	ame and Address 56h F/F Wabbe	l West	Balt:	imore, M	Approximate Interval
/Medical xaminer		falure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetic 1 Due to (or as a consection)		5	11			Between Onset and Death
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5, be executed sician and urial - transit	dical	X UNPENDED amended 23 a.	PII,2/,per	ME, g889	, 3/6/09	TT	M	
Division of Vital Records, P.O. Box 6876C the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. The funeral Director: After this certificate has been signed by the attending physiplety filled in by the funeral director, page 2 should be detached for use as the broad the funeral director, page 2 should be detached for use as the broad process.	sicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fet	al death 3 (Ectopic pregna	ancy	23d. Date of deliv Month	ery Day Year
P.O. Es that the gened by the edetached	by Phy	Part II. Other significant conditions contributing to death Hypertension; seizure di	but not resulting in the u	nderlying cause g	iven in Part I.			to the cause of death?
Vital Records, hysician: The law require this certificate has been sidirector, page 2 should b	Completed					24a. Was a autopo perfor	sy prior t med? death	
Vital F hysician: This certifical director, p	a	25. Was case referred to medical examiner? Hospital: 1 Innation	t 2 V ER/Outpatient	r	of Death (Check		Residence 6 Ot	her:
ion of V tending Phy eath. tor: After th	ation: To	1 ✓ Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28b. Time of Ir	njury 28c. Inju	ry at Work? (es 2 No	-	now injury occurred	
Division spital or Attendir hours after death. neral Director: A	ertification:		ry - At home, farm, stree	t, factory, office b	uilding, etc.	28f. Location (S or Town, S		Rural Route Number, City
To the Hospital within 24 hours To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.						
	Ĕ	29b. Signature and title of certifier Carbonian		29c. Licens O.C.I			29d. Date signed (#February 20, 2	
01		30. Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exar		Street, Baltin	nore, MD 212	201		
St Regist	ate rar	31. Date filed (Month, Day Year) 32. Fegistrar's EB 2 3 2009	Signature	KI				
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	State Registrar			Cer	tificate of t	Death			Reg. No.	009	0009
voicion	1. Decedent's Name (First, Mi	ddle, Last)						2. Date of De	eath Day	Year	3. Time of Death
ysician Vedical	Catherine A	yton Mosberg						Februa	ary 20	, 2009	11:54 a M
aminer	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat									unty of Death	
	Laurel Region 5. Social Security Number		A = 2 (la la		Laurel If Under 1 Year	If Under:	ON Hrs. T	0.0-140		nce Geo	
eral ector		6. Sex /. 1 □ M 2 🔀 F	Age (In yrs. la.	1 Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	Cour	
Clor	218-20-1686 Usual Residence of Decedent					ll		June	16,1927	/	MD
i .	10a. State 10b. Cou	nty	10c. City,	Town or Loc	ation					1	0d. Inside City Limits
or other traumatic event, the medical Examination was been difficult to the Completed by Funeral Director	MD Prin	ce George	Laur	el							1√XYes 2□No
Dire	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cour	ntry?
<u>ra</u>	333 11th Str	eet			20707				USA		
by Funeral Director	3 ☑ Widowed 4 ☐ Divore	If Yes, Give	es? ⊠No	lf lf	/as Decedent of H Yes, specify Cuba □Yes 2≹No	ispanic Ori in, Mexican Specify:	gin? (Spe ı, Puerto I	cify Yes or No Rican, etc.)		Race - Americ Black, White, e ecify: Whit	etc.
Completed	15. Dece	dent's Education	T	16a. Decede	ent's Usual Occup	ation			16b. Kind (of Business/Inc	dustry
Jple.	Elementary/Secondary (0-12	thest grade completed) 2) College (1-4)	or 5+)		ind of work done o O NOT use retired	during most f)	t of workir	ng			
00	12			Cleric	cal				Comca	ast Cab	le
å	17. Father's Name (First, Midd							(First, Middle		rname)	
ဥ	Albertus Ayt	on				Cat	theri	ne Per	nn 		
	19a. Informant's Name/Relation David A. Mosb			13419	Address (Street a	t., Hi					Code)
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	on 3 Removal from Sta (Specify)	ale		tion <i>(Name of</i> atory or other plac Cemetery	e) I	Feb. ^D			ion-City or To nore, M	•
any injury or other once.	21. Signature of Funeral Serv		1053		Name and Addres						, P.A.
ian cal	23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	ist only one cause on ead. a. Sersis	h line.		r the mode of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
ner	, and a second	500 00	as a conseque								
ē E	Sequentially list conditions, if any, leading to immediate	b. Respir	atory F as a conseque		5					1	0 days
Examiner	Sequentially list conditions, if any, leading to immediate cause. East underlying Cause (Disease or injury that initiated events	1									
Exa	resulting in death) Last	Due to (or	as a conseque	nce of):			-				
edical		d									
Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 Fetal d nt at time of dea	eath 3 🗆 :	Ectopic pregnancy Other <i>(specify)</i>	/			23d.	Date of delive	ery Day Year
	Part II. Other significant cond	litions contributing to deat	h but not resulti	ng in the und	lerlying cause give	en in Part I.		23e. Did 1	tobacco use d	contribute to th	e cause of death?
d by								1 🗆	Yes 2∏.N	lo 3□ Prob	ably 4 ☐ Unknown
Completed								24a. Was			
臣								auto		prior to cor death?	osy findings available npletion of cause of
	25. Was case referred to medi	on!					_	1 □Yes	2X No	1 🗆 Yes	2 ⊠ No
) Be	examiner?	Hospital:	ationt OFF	7/Outrations	Othe	· ·		(Check only o			
on: To	27. Manner of Death	28a. Date of I	atient 2 ☐ EF Injury 2 Day, Year)	8b. Time of Injury	28c, Injury Work			ne 5 ☐ Hesi 8d. Describe		Other (Specify curred	()
atio	L Coldon	stigation	-uy, 10a1)	л дат у		r Yes 2□N	No.				
Certification:		ld not be ermined 28e. Place of building,	Injury - At hometc. (Specify)	e, farm, stree	t, factory, office		2	8f. Location (City or To	Street and No wn, State)	umber or Rura	l Route Number,
Medical (29a. Certifier 1 Certifier (Check only one) 2 Medic	ying Physician: To the be al Examiner: On the basi and manner	s of examinatio	edge, death on and/or inve	occurred at the tin estigation, in my of	ne, date and pinion, deat	d place, a	and due to the	cause(s) and date and pla	d manner as st ce, and due to	tated. the cause(s)
Medical Certification	29b. Signature and title of cert	fier			29c. License	number			29d. Date si	gned (Month, L	Day, Year)
	722	0 0 - 0			7700				THEFT	77 D77 00	2000
	1 MW	Jour .			1)1796	52		J.	H.H.H.H.	JARY JU	. / (1) (1) (1)
Û	30. Name and address of pers	on who completed cause of	of death (Item 2	3a) (Type, Pr	D1296	52			FEBRO	JARY 20	,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 – For State Registrar	State of M	aryland /	Cer	rtificate of	ieaith and i Death	nemai my	Reg. N	2009	05392
	Physici	an	1. Decedent's Name (First, Middle Roscoe W. Maring	le, Last)					2. Date of De 2/21/200		Day Year	3. Time of Death 5:40 P M
	/Medic Examin		4a. Facility Name (If not institution 1701 Gillis Rd.	n, give street and number)		4b. City, Town, o	Location of Death			c. County of Death	
	Funeral Director		5. Social Security Number 217–36–4476		ge <i>(In yr</i> s. last b 83	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/3/192	th ay, Yea	9. Birth Cou	nplace (State or Foreign untry)
	ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	e Mary 3a-f sh uified	Director	MD Carrol	1	Woodbin	e						1 □ Yes 2x No
	vith th		10e. Street and Number				10f. Zip Code				Citizen of What Cou	,
	eath v	Funeral	1701 Gillis Rd.	12. Was Decedent	Ever in U.S.	13. \	21797 Vas Decedent of H	lispanic Origin? (Sr	ecify Yes or No		ited States	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evarriner must be nutified at	d by Fun	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 □Yes 2 ☑ If Yes, Give	?		fYes, specity Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
15-0	"natu	Completed by	(Specify only highe	nt's Education est grade completed)	16	a. Deced	lent's Usual Occup kind of work done	ation during most of work d)	ing	16b.	Kind of Business/I	ndustry
212	jene. r than	duo	Elementary/Secondary (0-12)	College (1-4or	· .	armer		•/		Aen	riculture	
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam				
Maryland	2 should be fi h and Mental H is marked ot raumatic ever	은	Jesse B. Maring	Turn Dulan	140	d. 84.70		Fdna Welsh		- 01	T. 01.1.2	
	1 and 2 st Health an em 27 is r		June Hidey Maring		170	01 Gi	llis Rd. W	and Number or Run	21797			
Baltimore,	permit. Pages 1 a Department of Her Important: If item any Injury or othe once.		20a. Method of Disposition 1 → Burial 2 □ Cremation	3 ☐ Removal from State	:		sition (Name of natory or other place		Date		Location - City or T	
altin	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (5 21. Signature of Funeral Service		Lake V	22	. Name and Addre	2/25/20 ss of Facility			esville, M	
ñ	permit. Departr Imports any Inji		Toll A	Kellow		Bu	rrier-Quee 12 v. old 1	n Funeral H	bme and (rema M	atory, P.A.	
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	d the death. Do		er the mode of dyin		or respiratory a	rrest,	7.217.74	Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions.	b								
- 13	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Cause (Disease or injury that initiated events	Due to (or as	s a consequence	e of):						
1,	an and rial-tra		that initiated events resulting in death) Last	C Due to (or as	a consequence	e of):						
876	icate be executed physician and the burial-transit	edical		d				<u> </u>				
Division of Vital Records, P.O. Box 68760,	at the death certific by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal deat at time of death		Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	very Day Year
ds, P.	ires that i signed by	þ	Part II. Other significant conditi	ons contributing to death	_	in the ur	nderlying cause giv	en in Part I.	23e. Did		/	the cause of death?
cor	w requir been s should	leted			11 "	1 }			24a. Was			
al Re	: The law cate has I	Completed							auto perfe		death?	topsy findings available ompletion of cause of
Vita	Physiclan: The tries certificate ral director, pag	Be o	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Oth	26. Place of Deal			A 1704	
) of	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of Inj		Time of Injury	28c. Injur Worl	y at	28d. Describe		6 ☐Other (Speci jury occurred	ify)
sior	tendin eath. tor: Af the fur	catic	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation			M 1 □	Yes 2 □ No				
Divi	l or At after o Direct d in by	Certification:	4 Homicide detern	ained 28e. Place of In	jury - At home, f tc. <i>(Specify)</i>	arm, stre	eet, factory, office		28f. Location (City or To	Street : wn, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical C	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best Examiner: On the basis and manner s	of examination a	ge, death and/or in	occurred at the tivestigation, in my o	me, date and place ppinion, death occur	, and due to the rred at the time,	cause date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifie	John (pr	emo		29c. Licens			29d. [Date signed (Month	, Day, Year) 1,2019
	5		30. Name and address of person	100 001	10-11 A		Print)	e 307 n	rsmin.	ster	MD :	2115)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Mad	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 27 per me, g886,02/23/09dhb Certificate of Death Reg. No. 2 Reg. No. 2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Frederick J. O'Connell 29 7:57 p^M 2009 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RELA R If Under 1 Year | If Under 24 Hrs. HARFORD BELAIR HEALTH AND REHABILITATION CENTER 8. Date of Birth (Month, Day, Year) Sept 7, 19 Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 94 114-10-5065 1914 Maryland Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No be notified Director MD Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 502 New Place Court 21014 'natural", or Items 23a USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Armed Folces:
1 Xes 2 No
If Yes, Give
Year or Dates: 41-45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mangone. clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Ignatius O'Connell Margaret Brennan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick O'Connell/son 502 New Place Court Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral 8 rvice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street mi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial Cause (Final disease or condition resulting in death) **Physician** erebrovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consendence off Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Subdural 1 Yes 2 No 3 Probably 4 Unknown hematoma Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending Fatter death. 5 Pending investigation **■ Ivat**ural 2X Accident Be. Place of injury - At home, farm, street, factory, office building, etc. (Specify) tell out of 1 Yes 2 No neral Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)
502 New Puce Ct. Belan: N 4 ☐ Homicide nome within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D 0863961 Junuary 30, 2009 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21078 Harrede Grace, MD 669 Revolution St. Benjamin Y. Lee, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 2 3 2009

FREDERICK

CONNELL

ORIGINAL

Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) _Month Year **Physician** February 18 2009 CMJ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayriew Medical Center Baltimore Cit Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) March 2, 1928 7. Age (In yrs. last birthday) Social Security Numbe 6. Sex **Funeral** Months 1□ M 2 F Days Hours 212-26-1126 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygleine. ant: If them 27 is marked other than "natural", or items 23a or 28a-f shoung or other traumatic event, it a Medical Examina must be notified at 1 ☐ Yes 2 No Director Sparrows Point Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21219 2111 Lodge Forest Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distillery Factory Worker 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Friendship Circle, Dundalk, Maryland Virginia Luberecki Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 20, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pur eral Service Licens Conneily Funeral Home Of Dundalk, P.A. 5 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Bowel 24 Yours Physician Ischemia /Medical resulting in death) Due to (or as a consequence of): Examiner rosepsis Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification, funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tes 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation

Division of Vital Records, P.O. Box 68760,

Certification: after death

Director; 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Medical Doctor

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

3 Suicide

4 Homicide

LOTVELE. Brown, John's Hopkins Boyview Medical Center, 4940 Eastern Avenue Baltimore, MO 21224

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009	05	395
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Noudon Fillavan		State of Maryland / Department of Health and Mental Hyg 1- For State Certificate of Death		200°	9 0539
Physicia Medical Examin	n/	1 Decedent's Name (First, Middle, Last) 2	Date of Death Month February 1		3 Time of Death 2319 hrs
(a)		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	r ebidaly i	4c. County of Death	
Famous		Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I if Under 24Hrs.	9 Date of But	hanannaa 0 Bu	halasa (State or
Funeral Director		n/a 1XM 2F 58 Yrs. Months Days Hours Min.		h(MM/DD/YYYY) 9 Biri Foreig 9 , 1 950 ^{Cor}	
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
Maryland 28a-f show	ě	MD BALTIMORE			1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	irec	10e Street and Number 10f. Zip Code		Og_Citizeri of What Cour	ntry?
with the ns 23a be noti	Funeral Director	401 S. NEWKIRK ST. 21224 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-		can Indian. Biack,
or iten	Fune	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	White, etc.	
5-0036 led within 72 hours after thygiene other than "natural", the Medical Examiner	최	3 Widowed 4 Divorced if Yes, Give Year or Dates:	irk done	Specify: ASI 16b. Kind of Business/I	
6 172 horan "na cal Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired	d)		
5-003 ed withir tygiene other th	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	First Middle M	EDUCATION	I
21215. uld be filee Mental Hy marked of	Be C				
nore, MD 2121 gges I and 2 should be fi nt of Health and Mental I tt If item 27 is marked other traumatic event,	岭	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ıral Route Num	ber City or Town, State	Zip Code)
ore, MD es 1 and 2 sho of Health and If item 27 is	-		E RIVER Date	20c. Location - City or	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: ARDENT 02/15	9/2009	HANOVER,	MT
Baltimo permit Page Department Important: injury or ot	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLE	EY CHAV	IS, JR. FNF	L. HM.
Physician	_	2007-09 EASTERN AVE 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r	E., BAL	TIMORE, MD	21231 Approximate Interval
/Medical		failure. List only one cause on each line Immediate Cause (had disease a Atherosclerotic Cardiovascular Disease			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
50, te be executed sysician and burial - transit	E E	d.			
O, e be ex- ysician burial -	ledical	UNPENDED AMENDED		004 Date (44)	
Box 68760, te death certificate be executed the attending physician and ned for use as the burial - transi			су	23d Date of delivery Month E	ay Year
that the death certifical ned by the attending phedeached for use as the	Physician/N	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown			
G t so				bacco use contribute to	
cords, P.C law requires that has been signed l	ompleted by	Diabetes Mellitus	1 Yes	2 No 3 Prot	topsy findings available
COTC law rec has be	nple		autop	sy prior to c	ompletion of cause of
Vital Recol	e Cor	25. Was seen referred to medical	1	2 No 1 Ye	s 2 No
Division of Vital Records, ra or Attending Physician: The law requir rs after death. "al Director: After this certificate has been sited in by the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director.	O B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing	Home 5	Residence 6 Other	
n of \ding Phy. h. After the function	on: T		28d Describe h	now injury occurred	
risio r Atten er deat irector	Certification:	2 Accident Investigation 13 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	28f. Location (S	Street and Number or Ru	ral Route Number, City
Div Hospital or 24 hours aff Funeral Di	Serti	Suicide 6 Could not be determined (Specify)	or Town, SI	tate)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			lue to the cause the time, date a	e(s) and manner as state and place, and due to the	ed e cause(s)
To the J within 2 To the Complet	Medical	and manner stated 29b Signature and title of certifier 29c. License number		29d Date signed (Mor	
		Q M, H		February 17, 200	9
7		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 212	01		(8007) , 34001
Sta	ate	31. Date filed (Month, Day, Year) 32; Registrar's Signature	.01		
Regist	_	ren 6 9 2000 Value / / /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18,19b perFH G888,2/25/09 WS
State of Maryland Department of Health and Mental Hygiene
Amend item#19b, perFH, G889,3/2/09, WS

Reg. No. 2 () () 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician 3:33 A M 14 2009 x Laurey Simms /Medical Rachel Mae 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dine. altimure 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1□ M **%**□ F 70 Director 05 SC 05 216-42-9281 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 X Yes 2 □ No **Funeral Director** Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r 21207 U.S.A 4702 Norfolk Ave Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2√2 No Specify. Specify: Be Completed by Black 3 ☐ Widowed 4 ☐ Divorced 'natural', Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rosewood State Elementary/Secondary (0-12) College (1-4or 5+) Hospital Certified Nursing Asst. 12th grade na **Maryland** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Nellie SVe Jackson John Paul Peterson Krown o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3464 Barkley Woods Road, Baltimore, Md 2121 19a. Informant's Name/Relationship (Type. Print) Troy Simms-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 2/20/09 Baltimore, Md permit. 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Deab 23a. Pant. Enter the disease, or complications shock, or heart failure. List only one caus the mode of dying, such as cardiac or respiratory arrest, m iate Cause (Final ase or condition resulting in death) **Physician** /Medical as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be execute equence of physician ar s the burial-ti Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Ö the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an autopsy performed?

1 Yes 2 No certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 20 1106 VERDANT & BACTIMORE 21117 NARREN 31. Date filed (Month; Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OBERT SUMMER 009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAI SPRING HOLY CROSS NER 8. Date of Birth (Month, Day, Year) MONTGOMER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreig Country) unk Sex 1 M 2 □ F Months Days Hours Min. **Director** 56 630 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Markel Examinating to another at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5501 20002 NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. <u>ک</u> 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) NUN NUN ENGINEER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) unk unk ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY HOSPITA CROSS SILVER SPRING MO 1500 FORBET GLENRO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟ Other (Specify) in state Wirector 21. Signature of Funeral Sorve Licensee Rand 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Stree Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): DISONDEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CEREBRAL Due to (or as a consequence of): Physician/Medical HUPERTENSI IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PHEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed THROMBOCYTOSIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? SUBSTANCE ABUSE - ELICIT DRUG AND ALCOHOL 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident

Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit

Physician

/Medical

Examiner

29a. Certifier (Check only one)

3 Suicide 6 ☐ Could not be 4 Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

EARTH PLACE LAUREL MD 20723

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier we

D5964

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IKECHUKWU 31. Date filed (Month, Day, Year)

MBONU 32. Registrar's Signature

8600 WNTAGE

State Registrar

			For State	State of Marylan		artment of F			200	9 05398
			Registrar 1. Decedent's Name (First, Middle, La	ast)		lineate or i	Dealli	2. Date of Dea		3. Time of Death
	Physici /Medic		James	C.		Smi	.th	Month O2	19 200	r
-	Examin		4a. Facility Name (If not institution, gi	ve street and number)			Location of Death	n	4c. County of De	eath
4			Shady Grove Ho			Roc If Under 1 Year	kville If Under 24 Hrs.	1 0 Date (D) 11	Montg	
и	Funeral			Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Da)	7. Year) 9. 5	Birthplace (State or Foreign Country)
	Director		213-38-5461 Usual Residence of Decedent	69				10 0	1 39	MD
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary a-f st	tor	MD Mont	gomery	Silv	ver Spri	.ng			1 □Yes 2 □XHo
	h the	irec	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show	al [2952 Beaverwood	od Lane		209	906		U.S.	A •
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and indiced an once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1√Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2☑No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, Wi	nerican Indian, nite, etc. Black
5-0	72 ho	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done o	ation during most of wor	kina	16b. Kind of Busines	s/Industry
21	ithin ne.	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)		Self Emp	loved
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ng	be fil htal H hd oth	Be	17. Father's Name (First, Middle, Las	t)				_{ne (First, Middle,} Mae Sm i	Maiden Surname)	
Ž	d Mer	ဥ	Eugene Beard		His					7.01
Maryland	12 st th an 7 is r traur		19a. Informant's Name/Relationship	,	19b. Mallir	ag Address (<i>Street</i>) 2 Beaver	ana Number or Hu	ano. Si	lver Spr	ing, Md
e,	1 and Heal em 2		Thelma Smith-V			sition (Name of matory or other place		Date	20c. Location - City	
Baltimore,	it. Pages rtment of rtant: If it njury or o		Burial 2 Cremation 3 L 4 Donation 5 Other (Spec.	ify) Gai	rriso	n Forest	Vet 2	/27/09	Owings	Mills, Md
Ba	permi Depar Impor any Ir		X Jerome A	. Thompson	Je Ma	Name and Addre arch F/F 300 Waba	i West ash Ave			
c.			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caulsed the deat one cause on each iine.	h. Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
-	Physician	İ	Immediate Cause (Final disease or condition	a Metastatic	Non	Small C	ell Lun	g Cance	er	Oliset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
		<u>.</u>	Sequentially list conditions,	b. — Due to (or as a conseq.	usces offe					
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	The se (c) do a see see	aerice oij					
_6	icate be executed physician and the burial-transit	xai	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
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.89	ifficat g phy as the	edic		u.		-				
.O. Box	Attending Physician: The law requires that the death certificardaath. sr death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	Ideath 3 □	Ectopic pregnanc Other (specify)	у		23d. Date of o Month	delivery Day Year
о, С	s that	by Pi	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	quire: en sig uld bi	q p						1 □ Y	es 2 □ No 3 □	Probably 4 Unknown
Records,	aw re	Completed						24a. Was a		autopsy findings available
Ä	The la	mo						autop:	med? death	o completion of cause of ? es 2 \(\frac{1}{2} \) No
ta	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	1 ∐Yes ath (Check only or	/\\	25 20110
of Vital	lysiclis ce		examiner? 1 🗆 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5 ☐ Resid	lence 6 Other (S	pecify)
Division o	iding Physician: th. After this certifical funeral director, p	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	yat ⟨? Yes 2 ∐No	28d. Describe h	ow injury occurred	
isi	Atten deat ctor: y the	fica	3 Suicide 6 Could not I	De 200 Place of Injury At he	ome, farm, str			28f. Location (S	Street and Number or	Rural Route Number,
Ö	al or safter	èrti	4 ☐ Homicide determined	building, etc. (Specif	y)			City or Tow	n, State)	
	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		hysician: To the best of my knominer: On the basis of examination and manner stated.						
	To th withii To th соттр	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)
) \RN	\sim	117	D3J	635		February	19, 2009
1	SX1 1		30. Name and address of person who					•		
	Sta	te	Joseph Kaplan, 31. Date filed (Month, Day, Year)	32. Registrar's Signa	tura					
	Registr	ar	FEB232	1009 / Jenne	p. 1	arked				

DHMH 17 Rev 1/2001

ORIGINAL

09-01297 Freddie Sterling Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certifica. Registrar	te of Death	Reg. No. 2009 0539
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Freddie Lee Sterling	2. Date (Month	of Death Day Pear Uary 13, 2009 3. Time of Death 1045 hrs
January.	4a. Facility Name (if not institution, give street and number) 53 Somers Core Apartments	4b. City, Town, or Location of Death Crisfield	4c. County of Death Somerset
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davis House Min	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
and show any nce.	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 53 Somers Cove Apartments	10f. Zip Code 21817	10g. Citizen of What Country? U.S.A.
fter death with F*, or items 23 for must be no Funeral	11. Marital Status 1 X Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et Yes 2 X No specify: 	
VID 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahomatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of work done ring most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-00; ed with tygiene other ti	9 Wat 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Mi	Utilities iddle, Maiden Surname)
21215-0036 ould be filed within 721 Mental Hygiene. In marked other than "tice event, the Medical ETO Be Complete	Wellington Sterling	Unknown	
AD 2 2 shoul h and N 27 is m imatic	IV.	Mailing Address (Street and Number or Rural Rou 06 Somerset Ave., Crist	
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, TO Be	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, Date	20c. Location - City or Town, State 2009 Hanover, maryland
Balti permit Departm Imports injury o	21. Signature of Funeral Service Libi nsee	22. Name and Address of Facility Ardent	Cremation Services Ste.N, Hanover, MD 21076
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		ory arrest, shock, or heart Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of H Due to (or as a consequence of):	ead	Death
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
t	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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'60, sate be exect physician am to burial - tr	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. Box 687 that the death certific ned by the attending p detached for use as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
ires that the d signed by the d be detached	Part II. Other significant conditions contributing to death but not resulting i		Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown
cords aw requents been 2 should			Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Vital Reco ysician: The law his certificate has director, page 2 s	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	160 2 160 2 160
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ion of tending Pheath. or: After the funeral the funeral ation: T	1 Natural 5 Pending FOUND: FOUND: FOUND: FOUND: 10000	D: 1 Yes 2 No Subject	t shot self
Division of Vital To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this cert completely filled in by the funeral directoed dedical Certification: To Be	- recordent introdugation	n, street, factory, office building, etc. 28f. Loca or Te	ation (Street and Number or Rural Route Number, City own, State) ers Core Apartments, Crisfield, MD
To the Hospital within 24 hours To the Funcral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.		
We are	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 14, 2009
	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	1
State Registrar	31. Date filed (Month, Day, Year) FER 2 3 2009 32. Recistrar's Signature	parkal	

Nichelle Antoinette Scarborough

State of Maryland / Department of Health and Mental Hygiene

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	F	- For State Registrar		Cert	ificate of	Death					eg. No.		In Time of Dooth
Physicia	n/	Decedent's Name (First, M	liddle,Last)						·2. [Date of Dea Month		'ear	3. Time of Death 1544 hrs
edical Examir	_		inette Scarbon					-1"(D	F	ebruary	18, 2009 4c. Count	y of Death	
7	4	4a. Facility Name (if not instit 3712 Lamoine Roa		nber)	4	b. City, Tov Randal		ation of D	eatn	E.C.		ore Cou	
	4			7. Age (In yrs. las	et hirthday)	If Under		If Under 2	4Hrs. 8	: Date of B	rth (MM/DD/YY	YY) :9. Bir	thplace (State or Foreign
Funeral		5. Social Security Number			10	Months	_	Hours	Min.		6-1968		ountry) MD
Director		21.3-90-7629	1 M 2 X F	·	40 Yrs.					10-2	0 1000		,.
	0.131	Usual Residence of Deceder 10a. State 10b. Cou		10c. City. 7	Town or Locati	on							10d. Inside City Limits
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faryland 28a-f show 1 at once.	<u></u>	MD 10e. Street and Number	arthore		- 10	10f. Zip C					10g. Citizen of	What Cou	ntry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23s or 28s-f she or trainmatic event, the Medical Examiner must be notified at once	Director	3712 Lamoine Ro	rad					21133				USA	
th the				edent Ever in U.S	13. Wa	s Decedent	t of Hispai	nic Origin	? (Speci	fy Yes or N	o- 14. Ra	ace - Amer	rican Indian, Black,
tens st be	Funeral	11. Marital Status Never Married 2	Married Armed Fo	rces?	If Y	es, specify	Cuban, M	lexican, Pi	uerto Ric	an, etc.)	W	hite, etc.	
er dez		3 Widowed 4 5	1 Yes Divorced If Yes, Give Year	2X No	1	Yes 2	X No s	specify:			Specif	Afric	an-American
ural mine	à	15. Decedent's Education	or Dates:		16a. Deceden	t's Usual O	ccupation	(Give kin	d of work	done.	16b. Kind of	Business	/Industry
2 hours a "natural	eted	Elementary/Secondary (0			during m	ost of worki	ing life. D	O NOT us	e retired)	D		-E Course trians
)36 hin 72 than edical	omple		4+		Regis	tered 1	Nurse				Depar	unent	of Corrections
5-0036 led within 72 Hygiene other than '	3	17. Father's Name (First, Mi	ddle, Last)					Mother's I	Name (F	irst, Middle	Maiden Surna	me)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than		William Scarboro	ngh					Dorot	hy A.	Stamp	er		
imore, MD 21215-003 Pages I and 2 should be filed within thent of Health and Mental Hygiene. frant: If item 27 is marked other th or other trainmatic event, the Neel	To Be	19a. Informant's Name/Rela									umber, City or T		e, Zip Code)
MD nd 2 sho atth and mi 27 is		Dorothy A. Sta	nper/Mother							stown,	MD 2113	on - City o	r Town, State
Heal Heal		20a. Method of Disposition 1 X Burial 2 Crem	nation 3 Removal fr	20b. F	Place of Dispos rematory or ot dlawn Ce	sition (Name her place)	e or ceme				1		
not of the Later		4 Donation 5 Other		Woo	dlawn Ce	metery	'		2-24-	-09	Woodl	awn, r	D
altir Sartun porta	40 A C C C C	21. Signature of Funeral Se											of Balto. Co.
Baltimore, MC permit Pages I and 2 sl Department of Health an Important: If item 27 injury or other trahma	1.1	Bran Lace	may	alie	92	200 Lib	erty_l	Road,	Randa	allstov	n, MD 21	133	T A
Physician		23a. Part I. Enter the disease failure. List only one co	e, or complications that	used the death.	Do not enter t	the mode of	f dying, su	ich as car	diac or re	espiratory a	irrest, shock, or	neart	Approximate Interval Between Onset and
Medical.		Immediate Cause (Final dis	Multiple Cu	nshot Woun	ds								Death
· .ammer		or condition resulting in dea	Due to (or as a	consequence of	·):								
- 7	٠	Sequentially list conditions,			ζ\.								
	ine	if any, leading to immediate cause. Enter Underlying C		consequence of	1.								
	Examiner	(Disease or injury that initial events resulting in death)		consequence of	f):						347		
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9 2 2	Physician/Medical	UNPENDED	AMENDED										
8760, iificate b ng physic	Me	IF FEMALE:		outcome of preg								e of delive	ery Day Year
687 ertific ding p	ian/	23b. Was decedent pregnar past 12 months?		oirth nant at time of de		etal death	3	Ectopic p	pregnand	у	Monf	L(1)	Day Teal
Box 68 e death certi	sici	1 Yes 2 No 9			5 0	ther (Spec	:rry)						
ords, P.O, Box 68 w requires that the death certi sheen signed by the attendin should be detached for use a.	Phy	Part II. Other significant c			esulting in the	underlying	cause giv	en in Part	t I.	23e. Die	tobacco use c	ontribute	to the cause of death?
P.O. s that the gened by										1	Yes 2 ✔ No	3 Pr	obably 4 Unknown
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OFC aw re nas be 2 sho	l gi									pe	topsy rformed?	death'	
Division of Vital Records, tal or Attending Physician: The law requiring after death. "In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed by									1 ✔ Ye	s 2 No	1 🗸	Yes 2 No
tal Rec cian: The certificate	Be	25. Was case referred to mexaminer?	Unanitation and		1		10	of Death (Other		_	Residence	6 100	ar: Soons
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Divisi	E E	3 Suicide 6	Could not be	ce of Injury - At h		eet, tactory.	, office bu	iliaing, etc		or Tow	n, State) oine Road, Ra		
Divisior Bospital or Attent 24 hours after death Funeral Director: stely filled in by the	Certification:	4 V Homicide		Single Far			V		_	_			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier (Check only one) Certify	ing Physician: To the be al Examiner: On the basis	st of my knowled	lge, death occ	urred at the	time, dat	e and place death occ	ce, and d curred at	lue to the c the time, da	ause(s) and ma ate and place, a	inner as s and due to	the cause(s)
To the within To the complet	Medical		and manner	stated.	aria/or irrestig		c. License						Month, Day, Year)
	Σ	29b. Signature and title of	certifier	(Jaco		290	O.C.N					ry 19, 2	
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			1 - For State Registrar	State of Ma	ryland /	Department of I Certificate of			ene g. No. 2009	05401
	Physici /Medio		Decedent's Name (First, Middle, Las BETTY	,	KOLOW			2. Date of Death FEBRUAR		3. Time of Death 2:35 A M
a de la companya de l	Examir		4a. Facility Name (If not institution, give SINAI HOSPITAL	street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	
ı	Funeral Director		5. Social Security Number 6. Se	9x 7. Age □ M 2√□ F	(In yrs. last bi			8. Date of Birth (Month, Day, 08/19/19		place (State or Foreign htry)
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				0d. Inside City Limits
	he Mar 28a-fst	Director	MD N/	A		BALTIMORE				1 X Yes 2 □ No
	th with t	ral Dir	10e. Street and Number 6807 PARK HEIGHT	S AVENUE,	#3E	10f. Zip Code	1215	10	g. Citizen of What Coul USA	ntry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I flems Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Machiel Examination in the Lind at once.	by Funeral	11. Marital Status 1 Never Married 2 Married Compared 4 Divorced	12. Was Decedent E- Armed Forces? 1		13. Was Decedent of Head of the Head of t	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH	etc.
7	I within 72 ho giene. r than "natu in Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire UBSTITUTE TE	during most of work d)	ing	6b. Kind of Business/In	
and	i be filed ntal Hygi ed other event, II	Be	17. Father's Name (First, Middle, Last)	OCKI			18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
laryi	2 should be and Mental is marked aumatic ev	၉	SAMUEL 19a. Informant's Name/Relationship (7		19b	o. Mailing Address (Street		al Route Number,	REEDMAN City or Town, State, Zip	Code)
ē, Ē	t and the salth tem 27 tem 27 other tr		KENNETH SOKOLOW / 20a. Method of Disposition	SON		BO7 PARK HEI f Disposition (Name of ry, crematory or other place)			ALTIMORE, N	
	Pages tment of tant: If it jury or o		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			ry, crematory or other plac EN CIRCLE CE	$M = \frac{02}{20}$	/2009 B	ALTIMORE, N	1D
0	permit. Departi Importa any inju		21. Signature of Funeral Service Licens	See 7	>	22. Name and Addre			SON & BROS. PIKESVILLE	
		88	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused t ne cause on each line	he death. Do	1 0	1	or respiratory arres	st,	Approximate Interval Between Onset and Death
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ć	eath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. HV Due to (or as a	consequence	worhic (ardion	mophy		
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U3, T.	ures mar signed by Id be deta	δ	Part II. Other significant conditions co	ntributing to death but	not resulting in	n the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
	has been s e 2 should	Completed						24a. Was an autopsy	24b. Were auto	osy findings available
ָ בּ	sician: The certificate his rector, page	Be Cor	25. Was case referred to medical			_	26. Place of Death	performe 1 □ Yes 2	d? death? X No 1 ☐ Yes	·
> .	r this ce	은	examiner? 1 ☐ Yes 2 🕍 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury			er: 4 🗆 Nursing Ho	me 5 Residen	ce 6 Other (Specify	/)
5	eath. or: Afte the fune	cation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year)	njury Worl	yat (? Yes 2 □No	28d. Describe how	injury occurred	
	a or Au s after d of Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	Route Number,
		Medical (29a. Certifier Check only one) Certifying Phy	rsician: To the best of iner: On the basis of e and manner state	examination ar	e, death occurred at the til d/or investigation, in my o	me, date and place, pinion, death occurr	and due to the cau ed at the time, date	use(s) and manner as s e and place, and due to	tated. the cause(s)
	withir To th сопр	Me	29b. Signature and title of certifier	NIN	П	29c. Licens	e number	J 9 29d	I. Date signed (Month,)	Oay, Year)
			30. Name and address of person who co	ompleted cause of dea	th/(Item 23a)	Type, Print) ld (oned n	d, Ba	Itmore.	7321608
	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 2 3 2009	2. Registra	s Signature	backer		<i>†</i>		-

09-01509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 Robert L. West State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 20, 2009 Medical Examiner 1702 hrs 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore** 225 Edgewood Street **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD) Y) 9. Birthplace (State o Foreign Mary and Months Hours Min. Director 216-50-4950 1 **X** M 2 F Yrs Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 23a or 28a-f show Baltimore notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Was Decedent Ever in U 14. Race - American Indian, Black a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married traumatic event, the Medical Examiner must Yes Yes 2 1 No specify: Yes, Give Year 5 -Specify: Black Widowed mit, Pages I e 12 should be filed sithin 72 hours airei parthein of Health and Mental Hygiene. portont. If item 27 is marked other than "natural"; ury or other traumatic event, the Medical Examiner. 4 Divorced 1975 ò 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DC NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Supervi ior 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Simmons Be -lurence ပ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Falls Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, X Burial 2 Cremation 3 crematory or other place) Removal from State Donation 5 Other Specify: Signature of Funeral Service Licensee 2h Name and Address of Sacility floor Funeval Service 1701 McCullo L St. Pallo Md. 2121 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autonsv prior to completion of cause of this certificate has page 2 s performed? death? Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Funeral Director: stely filled in by the Pending 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) February 21, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year egistrar's Signatu

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 05403 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 1030 AM Physician ARRY WINGFIELD AMONT -Porvary 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Poin NA DIVE Vursing BALTIMORE HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 2M 2□ F 63 220-42-8654 Vrs SEPTEMBERIE 1945 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f ehow vent, the Medical Examiner must be nutified at 1 Yes 2 No NA BALTIMORE MARYLAND Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525W.BELVEDERE AVENUE 2121 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE BJR ASSOCIATES 9TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 end 2 should be Health and Mental ie merked WINGFIELD MICHAEL ERMA ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2: Department of Health ar important: if Item 27 is eny injury or other trau page. 110 GRISTSTONE WAY, OWNIGS MILLS, MD 21117 BERNIE JACKSON (COUSIN) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 Cremation 3 Removal from State 02/24/2009 BALTIMORE, MARYLAND CADAR HILL CEM. 4 □Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
505EPH H. GROWN JR. FUNERAL HOME 23a. Part. Enter he disease, or complications that caused spock, or hy fit failure. List only one cause on each line lime stiate Carre (Final disease or condition of sulting in death) 2140 N. FULTON AVE, BALTIMORE, MD 21217 ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760. physicien Physician/Medical the ettending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ✓ No Z No : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Yes No Other: 1 Inpatient 2 ER/Outpatient Certification; To 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 6 To the Funeral [Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29s. License numbe ZLLO 2/16/2009 30. Name and address of person who completed cau of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

FEB 2 3 2009

31. Date filed (Month, Day, Year)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 19,2009 09:32 AM Valerie Stella Lee Wroten FEBRUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) Examiner BAUTIMON If Under 1 Year | If Under 24 Hrs. SAINT 16NES HOSFITAL 6 N/A Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🗙 F 59 12/02/1949 Maryland 214-54-1455 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a. State traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2X No Director Baltimore MD Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2200 Gayland Drive 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ∐Yes 2 🛣 No Specify: Specify: \$ 3 Widowed 4 Oivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 <u>Homemaker</u> Own_Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Harlan Brehm Estella Mae Brehm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Mr. Daniel T. Wroten (Son) 2200 Gayland Drive, Halethorpe, Maryland 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/20/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Maila 4107 Wilkens Avenue, Baltimore, Maryland 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease become shock, or heart failure. List only Immediate Cause (Final 7 DAYS Physician METASTATIC SQUAMONS CELL LUNG CANCE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760, certificate has

and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

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items 23a

'n,

'natural",

and Mental Hygiene.

Pages 1

cate has been signed by the page 2 should be detached To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

P23495

FEBRUARY 19, 2009

30. Name and whiress of person who complete deat (Item 23a) (Type, Print)

and manner stated.

6 ☐ Could not be determined

au

3 Suicide

29a. Certifier (Check only onel

4 ☐ Homicide

29b. Signature and title of certified

CATON AVE, BALTIMINE MD 21229 MID 900 SUCHANGEO 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. 20, Day 2009 Year Physician Horace C. Wisniewski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2019 Holborn Rd. Dundalk Baltimore 8. Date of Birth (Month, Day, Year) .Tilly 31, 1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F Maryland 212-16-9478 91 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 Holborn Road 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 233 any injury or other fraumatic event, the "Norion Examinal". Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Ś Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Weigher Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John S. Wisniewski Anna H. Kocyan ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Wisniewski wife 2019 Holborn Road, Dundalk, Maryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February Important: If it any injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery 23, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, attending p Division of Vital Records, ours after death.

leral Director: #
filled in by the fi

þ

Be Completed

Certification: To

Medical

in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4 Pregnant at time of death 9 Unknown

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> Month Day Year 23e. Did tobacco use contribute to the cause of death?

ANJIENT ISCHEMIC ATTACK

24a. Was an

25. Was case referred to medical examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Mapner of Death 1 ➡ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signatu and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9600 KISHORE MO.

State

29a. Certifier

31. Date filed (Month, Day, Year) ...

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

24 hours

соmpletely

ORIGINAL

3 Time of Death

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

11:15 a^M

1 Yes 2 No 3 Probably 4 Unknown

autopsy perform ?? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NORTH PT. RD. FORT HOLIMAD.

			1 – For State Registrar	State	of Mary	/land / D				lealth a Death	and M	lental H			009	05	406
	Physici	an	1. Decedent's Name (First, Middle VINCENT WILK									2. Date of D Month	Death	Day	Year	3. Time of 2017	
1	/Medic Examir		4a. Facility Name (If not institution	, give street and no				4b. City,		Location of	f Death	_ Z	4		2009 y of Death	2011	
À	Funeral	-	5. Social Security Number	6. Sex		n yrs. last birt	hday)	If Under Months	,	If Under 2	24 Hrs. Min.	8. Date of E	Birth Day Yea	r)		lace (State o	r Foreign
	Director		212-60-7691 Usual Residence of Decedent	1 2 M 2 □ F		56`	Yrs.	WOTHIS	Days	riouis		JUL. 2		952	Coun	MD	
	Iryland show	_	10a. State 10b. County		10	c. City, Town	or Loc	cation							11	Od. Inside Cit	
	the Ma	Director	MD 10e. Street and Number			BALTIM	ORE	10f. Zip	Code				100 (Citizen of	What Coun	1 XYes	2 No
	h with	al Di	3931 EDMONDSON	AVE.				212					US		Wilat Court	uy:	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, It a Modical Evanther must be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☒ Divorced	12. Was Dec Armed F	orces? 2 X No iive	r in U.S.	li it	Vas Deced Yes, spec	ify Cuba	spanic Orig n, Mexican, Specify:	gin? (Spe Puerto	ecify Yes or N Rican, etc.)		14. Rad Bla	ce - Americ ck, White, e fy: BLA	tc.	
215-0036	thin 72 hou ne. nan "natura nan "natura	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	's Education t grade completed,			(Give H	lent's Usua kind of wo OO NOT us	k done d	lurina most	of workii	ng	16b.	Kind of B	usiness/Ind	ustry	·
17 D	e filed wi al Hygier other th		12TH 17. Father's Name (First, Middle,	Last)		I	ABO	ORER		18. Mother	's Name	(First, Middi		DELIN			
lan	e a ai	To Be	DAVID WILKINS							MTLDR			o, maioc	or ourrain	110)		
Maryland 21	12 shol h and t 7 is ma trauma	. 3	19a. Informant's Name/Relations			1						l Route Num			•	Code)	
വ്	ss 1 and 2 should b of Health and Men! item 27 is marked r other traumatic e		DEANNA JOHNSON/ 20a. Method of Disposition	SISTER	2	20b. Place of cemeter	2242 Dispos	2 PEN sition (Nan	ROSE	AVE.		LTIMOF ate	20c.	Location -	- City or To	wn, State	
Baltımore,	Page: ment o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		rrin	VTIV		0	2/20	/2009	550 BAI	יס טט אדידאס	DONNE	ILL ST. ID 212	
Ball	permit. Pages 'Department of Important: If ite any Injury or of once.		21. Signature of Funeral Service	Licensee		2	22.	Name an	d Addres	s of Facility	WESL	EY CHA	VIS	, JR.	FNRI	. HM. 21231	
	Physician /Medical Examiner		23a. Part 1. Enter the disease or shock, or heart failure List Immediate Cause (Final disease or condition resulting in death)	a. Fun Due fo	or as a co	ENDOCO	د که i · of):		e of dying	g, such as o	cardiac c	r respiratory	arrest,			Approximate Interval Betv Onset and D	veen
-	ed sit	niner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events			onsequence o									-1		
8/60,	cate be executed physician and the burial-transit	dical Examine	that initiated events resulting in death) Last	c Due to	(or as a co	nsequence o	of):										
20 X	sertifica ding ph	/Medi	IF FEMALE:	O2a If you as	stacme of a												
O. Box	the death or by the atternached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ gnant at tim	Fetal death		Ectopic p Other (sp							ite of delive		ear
ords, F	equires that sen signed l ould be det	ρ	Part II. Other significant condition	ns contributing to c	leath but no	ot resulting in	the un	derlying ca	use give	n in Part I.			tobacco			e cause of de ably 4덟U	
Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed										24a. Wa auto per 1 □Yes	opsy formed?		Were autop prior to con death? 1 □Yes	osy findings a npletion of ca 2 □ No	vailable use of
=	ysiciai is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	Inpatient	2 ☐ ER/Out	patient	3 □ DC	A Othe			<i>(Check only</i> ne 5 ☐ Res		6 🗆 Ott	er (Specific	1	
DIVISION OF	tending Ph eath. tor: After th the funeral	Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin, 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	28a. Date (Mor	of Injury oth, Day, Ye	28b. T	ime of njury	M 2	3c. Injury Work 1 □ Y		2	28d. Describe				/	
2	urs after of rral Direct rral Direct		4 Homicide determ	ned 28e. Plac build		At home, far Specify)						28f. Location City or To	ówn, Sta	te)			er,
	the Hosp hin 24 ho the Fune npletely fi	Medical	(Check only 2 Medical one)	g Physician: To th Examiner: On the and mar	e best of m basis of exa nner stated.	y knowledge, amination and	, death d/or inv	estigation	in my op	oinion, deat	d place, a	and due to the	e, date a	nd place,	and due to	the cause(s)	
) i	o o o ii	-	29b. Signature and/title of certifier	MD					License	,					d (Month, E		
	V		30. Name and address of person Hanh Ti	who completed cau ルピルタ	se of death	(Item 23a) (S,	Type, P	rint) eeN		Ba	1hm	ore	MI.	21	1201		
	Sta Registr		30. Name and address of person Han \(\lambda \) 31. Date filed (Month, Day, Year) FER 2 3 20	32.	Registrar's	Signature	ark	1									
DUA	IH 17 Rev 1/2		FFR2370	UJ North	,	- 17											

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 05407 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 245PM **Physician** 108 CALYN LOUISE WILKES Juage /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home Hos tal 2 words to If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min Director 219-62-2883 FEB. 8, 1956 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show Director 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 12 S. CURLEY ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tyes 2 No. Specify Specify: BLACK þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Many Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ SAMUEL WILKES LOUISE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AKIA GILL/DAUGHTER 12 S. CURLEY ST., BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/09/2009 HANOVER, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service License 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the ding se, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail the. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) oborachno. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if the same senter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of). attending physician for use as the burial Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown o 9 Unknown signed by I ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? yes 2 11 No DXX 2 No 1 □ Yes 1∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖼 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AEBRUARY, 4, 2009 D28855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Sinac Wospital MO 31. Date filed (Mönth, Day, Year) 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () 05408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day February 07,2009 0150 James C. Allen Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Cheverly Prince George Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | 922 5. Social Security Number Birthplace (State or Foreign Country) 1XM 2□ F 579-18-2558 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits Capital Heights Prince George Md 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 6307 liberia Street USA 12. Was Decedent Ever in U.S Amed Forces? 01_4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status types Give 26/04/46 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't(GSA) Courier 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James T. Allen Bessie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie M. Allen (Wife) 6307 Liberia St.Captial Heights Md.20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Cheltenham Vet Cem02-19-09 Cheltenham Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part1. Enter the disease, or conshock or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Hypoxemic Respiratory Failure disease or condition resulting in death) weeks Due to (or as a consequence of) Interstitial lung disease 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary Hypertension 1 Yes 2 No 3 Probably 4 Striknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

ng physician and as the burial-transit The law requires thet the death certificate be executed P.O. Box 68760, attending p of Vital Records, director, Division

Examiner Completed by Physician/Medical Hospitel or Attending Physicien: Be Certification: To s efter death. Il Director: After this id in by the funeral d filled To the Hospitel within 24 hours e To the Funerel E Medical

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

'naturel', or iteme 23a

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiny or other traumatic event size.

Physician

/Medical

Examiner

e filed within 72 hours after al Hygiene. other than "naturel", or ite

Baltimore, Maryland 21215-0036

other traumatic event, the Madical Examiner must be notified at

Funeral Direc

þ

Completed

Be

2

the Maryland

completely 10+1 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Revathy Murthy

31. Date filed (Month, Day, Year) FEB 1 0 2009

6130 Landover Rd. Cheverly Maryland 20785 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/states.

29c. License number D16273 MD

Registrar

29a. Certifier

(Check only one)

29b. Signature and

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Keister Nicholas Adams 4:50 P M 2009 February 2, /Medical Aa Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Days XXM 2□ F Months Hours 573-34-1326 85 23, Oct. 1923 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinatment be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2√No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 376 Forelands Road 21401 U.S.A. by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? ▶CXYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 White 1 □Yes **2**No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Executive U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Keister Adams Hope Nicholas Pages 1 and 2 should ္ပ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: if item 27 is any injury or other trains once. Elizabeth Adams/wife 376 Forelands Road Annapolis, Maryland 21401 altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition ₩XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 2/6/2009 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preymonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by Kidney Disease 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 autopsy performed Fibrillation 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 - No i or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the Funeral Director: After the mpletely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical (Check only and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D00058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center, Annapolis MD 21401 Annetvund MD Howtra OUNE 32. Begistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001 FEB 04 2009

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	For State Registrar	otate of marylan		rtificate of		a Wertal II	Bea No 2 (009	05411
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Examine	4a. Facility Name (If not institution, give 998 Miller Circle	street and number)		4b. City, Town, o	r Location of De	eath		-	ndel
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Physician //Medical	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death ne cause on each line. Due to (or as a consequence)	DC						Interval Between
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State Registrar	31. Date filed (Month, Day, Year) FER 0 3 2	32. Registrar's Signato	Ø. 4	backer				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh g888 2-25-09 vt 23e per doc State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Februar Physician Day Year SHIRLEY 2009 BARNETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES Age (In yrs. last birthday). 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1924 Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Months Days Hours Min. 452-30-3137 LOUISIANA Director 09-11-1927- Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Event har near be natified. 1X Yes 2 No Director UPPER MARLBORO MD PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13011 FOX BOW DR. 20774 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: BLACK 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) **GOVERNMENT** LIBRARIAN 4YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PRESTON ပ RODGERS RUTH **EVANS** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **JEROME** BARNETT / Son 13011 FOX BOW DR., UPPER MARLBORO, MD 20774 Department of Heali Important: If item 2 any Injury or other once. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROLLING HILLS MEM. PARK 2/20/2009 RICHMOND, CALIFORNIA 4 Donation 5 Other (Specify) 21. Signature of Funer Service License 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST. NW, WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or 35 a consequence of): Examiner Rymonic Sequentially list conditions, if any, leading to him, ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trans Due to (or as a consequence Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 □Yes 2 🗷 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>چ</u> 1 ☐ Yes 2 No Shriobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate me 2 No of Vital 1 □Yes 2 No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 Ar Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 □ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0052500 who completed cause of death (Item 23a) (Type, Print) ABDULWAHABE M.S. 8118

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

FFR 10 2009

SAFWETT Shirley

32. Registrar's Signature

				1 - For State Registrar	State of Mary	land / De	partment <i>ertificate</i>	of H	ealth a Death	and M		giene Reg. No.		054	13
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<u>ڜ</u> ×	death certific attending p	/Med	IF FEMALE:	23c. If yes, outcome of pregnance								
O. Box	he death of the attentiched for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3□	Ectopic pregnancy Other (specify)	y			23	d. Date of delive Month	ny Day Year
σ,	res that the de signed by the a be detached i		Part II. Other significant conditions	contributing to death but not resulti	ng in the ur	derlying cause give	en in Part I.		23e. Did to	bacco use	e contribute to th	e cause of death?
g	w requires been sig should be	ed by							1 □ Y	es 21	Ño 3□ Prob	ably 4 ☐ Unknown
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o	Physic ruthis cral direct	٠ <u>.</u>	1 ☐ Yes 2 ANo 27. Manwer of Death	Hospital: 1 Inpatient 2 El	R/Outpatien 8b. Time of		4 LI Nur		5 Resid		Other (Specify)
<u>o</u>	nding ath. :: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	28c. Injury Work	رِيَ Yes 2 □ N	1	. Describe n	ow injury c	occarred	
Divis	affe Dir	Certification: To	3 Suicide 6 Could not 4 Homicide determined		e, farm, stre	eet, factory, office		28f.	Location (S City or Tow		Number or Rura	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in In	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my knowl miner: On the basis of examination and manner stated.	edge, death on and/or in	occurred at the tir restigation, in my o	me, date and pinion, deat	d place, and th occurred	due to the at the time, o	cause(s) a date and p	and manner as s place, and due to	tated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licenso	e number			29d. Date	signed (Month,	Day, Year)
			grene (1	70		65	787)		0	2/09	12009
R	10		30. Name and address of person who Adamu A 31. Date filed (Month, Day, Year)	o completed cause of death (Item 2	06	arrell	A	le.	Talo	ome	part	CIMD
	Sta Registr		FEB 1 0 2009	32. Registrar's Signatur	Ken						<i>ν</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 05415 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** P^{M} February 7:40 Thierno Suleymane 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park
If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 1954 55 3, Feb. Guinea Director 064-78-9927 Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Expressions to ust by motified at 1 ☐ Yes 2 ☐ No Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Guinea 11235 Lockwood Drive Apt. 108 20901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify:Black ۵ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Tailer 12 should be filed with and Mental Hygier 7 Is marked other th Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk. Kadiata BouBacar Bah ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any Injury or other trau once. Ousmane Bah (Brother) 4303 Baychester Ave., Bronx, NY 10466 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Family Plot 2/13/09 4 ☐ Donation 5 ☐ Other (Specify) Guinea, West Africa 22. Name and Address of Facility
Bergen Funeral Service 21. Signature of Funeral Service Llomsee 232 Kipp Ave., Hasbrouck Heights, NJ 07604 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) failure Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Fuheral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit elmonio resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 A No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

FEB 1 0 2009

32. Registrar's Signature

7600

address of person who completed cause of death (Item 23a) (Type, Print)

		1	For State		State	of Mai	ryland /		rtment tificate				ental Hy	giene	20	09	05416	5
			Registrar 1. Decedent's Nam	ne (First, Middl	e. Last)			Cei	incate	- 01 D	eaur		2. Date of De		. 2 0		3. Time of Death	<i>)</i>
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and			Usual Residence o 10a. State	f Decedent 10b. County			10c. City, To	wn or Loc	ation							10d	. Inside City Limits	-
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af	Madical		29a. Certifier (Check only one)	1X Certifying	ng Physician: To the	e best of basis of e	examination.	ige, death	occurred a restigation,	t the time In my opi	e, date a	nd place, a	and due to the	cause(s date and) and mad place,	anner as stat and due to th	ted. ne cause(s)	1
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			For State Registrar	State of Maryl		artment of F		, 0	ene 3. No. 2009	05417
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth Mary	Barbieri				2 Date of Death		3. Time of Death 8:20A M
A. Carrier	/Medic Examir		4a. Facility Name (If not institution, give s 344 Overlook Driv				r Location of Death Frederic		4c. County of Death Calvert	
	Funeral Director		3,7 10 7137		vrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. J	8. Date of Birth (Month, Day,)	Cour	place (State or Foreign ntry) PA
	e Maryland 3a-f show	ctor	Usual Residence of Decedent		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	Funeral Director	10e. Street and Number 6097 Red Squirre	l Place		10f. Zip Code 2060	03	100	g. Citizen of What Coul USA	ntry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational be institled at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	within 72 ho liene. r than "natur hy Wedical I	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired Homema	during most of work d)	ing 16	Sb. Kind of Business/In	,
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than any Injury or other traumatic event, Im. M. DICE.	To Be C	17. Father's Name (First, Middle, Last) Louis Sacchetti					e (First, Middle, Ma Anne Le		
, Mar	and 2 sho saith and I n 27 is ma er trauma	ľ	19a. Informant's Name/Relationship (Type Christine Eberle/I				and Number or Run		City or Town, State, Zip f, MD 2060	
Baltimore,	nit. Pages 1 a artment of He ortant: If Item Injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Ma	b. Place of Dispo cemetery, crer aryland	sition (Name of matory or other place Veterans	Cem. 2/1		oc. Location - City or To eltenham, M	
Balt	permit. Departs Imports any Inji		21. Signature of Funeral Service License	Echola	200945		-ECHOLS FI			616
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line. Due to (br as a con	leath. Do not ent		ng, such as cardiac		1	ADFOXIMATE Interval Between Onset and Death
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Division o	Jing After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Yea		M 1 □	Yes 2 □ No	28d. Describe how		**
ρίς	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or Town,		
	To the Hos within 24 ho To the Fun completely	Medical	one)	Ician: To the best of my er: On the basis of exar and manner stated.	nination and/or in	ivestigation, in my d	opinion, death occur	and due to the cau	use(s) and manner as s te and place, and due to	stated. to the cause(s)
	To with	2	29b. Signature and title of certifier.	<u>`</u>		29c. Licens	e number 3352		d. Date signed (Month, ebruary 6,	
	В		30. Name and address of person who co	D. 3500 01d	l_Washin	gton Road	l, Waldorí	,MD 206	02	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 6 20	32. Registrar's Si	gnature A	haves				

		1 State Registrar		Ce	rtificate of	Death	-,	Reg. No.	2009	054
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Exam		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Dea			unty of Death	_ 0.0, _
		204 TALBOT RD. 5. Social Security Number 6.	Sex 7. Age	//		NSVILLE			EEN AN	
Funera Directo		230-14-5012	1 □ MM 2 □ F	(In yrs. last birthday) 85 Yrs.	Months Days	Hours Min		v. Year)	COUR	olace <i>(St</i> ate o <i>r Fo</i> otry) GINIA
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City L
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or 28a	Funeral Director	10e. Street and Number		01110	10f. Zip Code		· ·	10g. Citizer	of What Coun	ntry?
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ems	neu	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of I	Hispanic Origin? (Specify Yes or No-	- 14.	Race - Americ Black, White, e	
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rayer nent o		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		20b. Place of Dispo cemetery, cree STEVENSVI	matory or other pla		UARY 7		ion - City or To $ISVILLE$	wn, State , MARYL
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li	2416.6.		2. Name and Addre					
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. e 2	Completed						24a. Was a autop perfor	sy	4b. Were autop prior to con death? 1 ☐ Yes	osy findings ava
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sertificate has bector, page 2 sl		1 Yes 2 No		t 2 ER/Outpatier		4 L Nursing F	lome 5 ☐ Resid	ence 6X	Other (Specify	RESIDE
this certificate has ball director, page 2 sl	ြို		28a. Date of Injury	Year) 28b. Time of Injury	Wor	k?	28d. Describe h	ow injury oc	curred	
After this certific uneral director, I	ြို	27. Manner of Death 1 ■ Natural 5 ■ Pending	(Month, Day,							
for death. The rail report of the form of	ြို		oe 280 Place of Injur	y - At home, farm, str (Specify)		Yes 2□No	28f. Location (S City or Tow	treet and No	umber or Rural	Route Number
ter death. irector: After this certificate has n by the funeral director, page 2	Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of Injury building, etc.	(Specify)	eet, factory, office		City or Tow	n, State)		
After this certific uneral director, I	ြို	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying P	pe 28e. Place of Injury	(Specify) my knowledge, deatlexamination and/or in	eet, factory, office	ime date and place	City or Tow	n, State)	d manner as st	ated

DAVID SMITH, M.D. State Registrar

8221 TEAL DRIVE, SUITE 302, EASTON, MD 21601

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D39887

FEBRUARY 5, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2 Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Febth 3 2009 **Physician** PM Carole Sue Bennett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broomes Island Calvert 4067 Songbird Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Dec 27 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 217 46–6793 **Funeral** 1 □ M 2 🗙 F Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County r 28a-f show notified at 10a State 1 ☐ Yes 2 TNo Director Maryland Calvert Broomes Island 10f. Zip Code 20615 10g. Citizen of What Country? 10e Street and Number 4067 Songbird Lane r than "natural", or Items 23a or the Medical Examiner must be n United States Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 K Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Fed Gov. / CIA Analyst 12th 7 Is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Arthur Robert Bennett, I Velma Gaston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Arthur Robert Bennett, II- son 44944 Canvasback Dr. Callaway, MD 20620 Baltimore, 20c. Location - City or Town, State Alexandria Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 4 2009 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee BRause 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diabetes Mellitu Physician /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Hyperlipidemia

Due to (or as a consequence of): and as the burial-P.O. Box 68760 physician certificate be Physician/Medical signed by the attending r IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 | Yes 2 | No 3 | Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 4 Residence 6 Other (Specify) NaYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ ospital or Attending Physical fours after death.

Ineral Director; After this in by the funeral di 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 124 hours af Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature ess of person who completed cay e of death (Item 23a) (Type, Print) add 30. Name an

DHMH 17 Rev 1/2001

State Registrar 32. Registraris Signature

SWUTE 310 Prince Frederick M

	-	For State Registrar	State of Ma	ırylan	•		nt of H <i>te of L</i>		and Me		giene Reg. No.	200	9 05	420
		1. Decedent's Name (First, Middle, La	st)					-	2	. Date of Dea	ath		3. Time of	Death
Physicia /Medic		Raymond	D. Brev	ær						Honth	Day.	2009	1414	C M
Examin		4a. Facility Name (If not institution, giv	e street and number)	/	, ,	4b. City	, Town, or	Location of	f Death		4c. 0	County of Dea	th	
		Prince Ge	oyes H	DS F	rital		Lov	2/	5			ince	6 core	5
Funeral		5. Social Security Number 6. S	EM 2DE		last birthday) Yrs.	Months	Pr 1 Year Days	If Under A	Min. 8	(Month, Da	h y, <i>Year)</i>	C	thplace (State o	_
Director	-	218-38-2910 Usual Residence of Decedent		70						3–10-	-38	M	arylan	<u>a</u>
yland yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	ty Limits
Mar med	흕	MD. P.G	•	S	pring	dale	9						1 X Yes	2 □ No
th the or 28	Director	10e. Street and Number					ip Code					en of What C	1	
23a ust b	필	9506 Etica P	lace				2077		_			U.S.A	•	
1215-0036 within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Deci	edent of Hi ecify Cuba	ispanic Orig n, Mexican,	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)	1	 Race - Am Black, White 		
36 safte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 N If Yes, Give Year or Dates:	lo		1 □Yes	2 No	Specify:				Specify: ${f B1}$	ack	
-00 hour	ed l	15. Decedent's E			16a. Dece	dent's Us	ual Occupa	ation			16b. Kin	d of Business	/Industry	
215	Completed	(Specify only highest gra	ade completed) College (1-4or 5	. \	(Give life.	kind of w	ork done d use retired	luring most)	of working				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
212 d with giene	Ĕ	8th	College (1-4015	+)		Mec	nanio	C			Pr	ivate		
nd e file al Hy rothe	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	First, Middle,	Maiden S	Surname)		
Vlai Ment Ment arked	١٩				1	Unkr	lown	E	velyr	Ewe.	Ll			
Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hygiene. Its marked other than "natural", or traumatic event, the Medical Event traumatic event, the Medical Events.		19a. Informant's Name/Relationship (**			-					-	Town, State,		
and and Health	-	Barbara T. Br	ewer/Wife	_							<u> </u>	d. 20		
Saltimore, permit. Pages 1 an appartment of Heal appartment of Heal appartment. If Item 2 my Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	1	Place of Dispo cemetery, crer				Date			ation - City or		
timer trmer rtmer rtant:		4 □ Donation 5 □ Other (Special		Ri	verda				2/11/				e, Md.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	Hacken	A	, 22					al Cha		, Inc	•	
Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	the death e.	h. Do not ent			g, such as o		0	rest,	- Dic	Approximate Interval Bet Onset and D	ween
/Medical Examiner		resulting in death)	Due to (or as	-	uence of):							9.0		
LXaiiiiiei	_	Sequentially list conditions,	b							-				
outed uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence or):									
an xec	Xar	that initiated events resulting in death) Last	c Due to (or as a	a conseq	uence of):									
8760, cate be e	dical E	(d											
	edi		- u.											
Box 6 eath certifi	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			7					2:	3d. Date of de	livery	
P.O. Box at the death cer by the attendin stached for use	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at	time of		Other (pregnancy specify)	<i>'</i>				Month	Day Y	'ear
P.C at the d by th	څ	9 Unknown								1				
on of Vital Records, P.O. ding Physician: The law requires that the den. After this certificate has been signed by the funeral director, page 2 should be detached	P P	Part II. Other significant conditions		it not resi	ulting in the u	nderlying	cause give	en in Part I.					o the cause of d	_
ord requir	Completed	Diabel	, es							1 U Y	′es 2□]No 3∏ F	robably 4.	Inknown
law las b										24a. Was autop		24b. Were a	utopsy findings a completion of ca	available ause of
The	_등									perfor 1 ☐ Yes	med?	death?	s 2 No	
Vital Records, stclan: The law requires the certificate has been signer rector, page 2 should be de	Be	25. Was case referred to medical examine?	Linenital:				Tou.		of Death (Check only o	ne)	-		
Of Physical this cal direction	<u>e</u>	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatier			4 LI Nur				Other (Spe	ecify)	
on of ding Phys	ioi	27. Manner of Death 1	28a. Date of Inju	y (Year)	28b. Time of Injury	М	28c. Injury Work	yat :? Yes 2 □N		d. Describe h	iow injury	occurred		
Division of or Attending Physafter death. Director: After this in by the funeral di	ical	3 ☐ Suicide 6 ☐ Could not b		irv - At ho	ome farm str			res ZUN		Location (6	Stroot and	Numberor	ural Route Num	hor
Div	Certification: To	4 ☐ Homicide determined	building, etc							City or Tow	(n, State)			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certificate thours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Example)	nysician: To the best of miner: On the basis of and manner sta	examina	owledge, deat ation and/or in	vestigatio	on, in my o	pinion, deat	d place, an th occurred	d due to the at the time,	cause(s) date and	and manner a place, and du	is stated. e to the cause(s)
vith To t	Σ	29b. Signature and title of certifier	11 +	7 34			9c. License					signed (Mon		
4		Salvador.	Spregler	100	>		400	537	2		Tel	runy	-4, 200	9
		30. Name and address of person who	completed cause of de	eath (Iten	n 23a) (Type, Hosp	Print)	1 -			/	1	7	//	
		31. Date filed (Month, Day, Year)	92. Registra	or's Signa	HOSP	Ita	10	12-00	10	Love	13	Mar	gland	
Sta Registr	_	EED 0 6 200	IQ A. Hegistia	a oigna	ha	4.1		,						

State of Maryland / Department of Health and Mental Hygiene State Registra NFND#8, 10a-c, e, f+18perINF2/17/09, By Registra NFD Re 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 11:55 am Harold Eugene Brown, Jr. February 2009 0.3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dag)
July 24, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1⊠M 2□F **Director** 302-07-1187 88 1920 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. StateMD 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shore Examples to rectified at North Montgomery Silver Spring 1 ☐Yes 2KINo Director Mecklenburg Sarolina · Charlotte 10f. Zip Code 10g. Citizen of What Country? Street and Number 20906 14400 Homecrest Road #104 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1941-1967 Completed by 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ital Institution or other traumatic event, Ital Institu Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer United States Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden_Surname) Be Hedleston ပ Harold Eugene Brown, Sr. Florence Huddles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Brown - Son 1215 Santa Anita Way, Sevierville, Tennessee 37876 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Highland Memorial Park 02/07/2009 4 Donation 5 Dother (Specify) Knoxville, Tennessee 21. Signature of Funeral Service Lice See 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Ham shire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the dial ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause IFI Physician Gangrene Left Lower Limb 2 days disease resulting in death) /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Vascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran 68760,7 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hypertension, Recurrent Pneumonia, Acute Renal Failure 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Failure to Thrive, Generalized Vascular Disease autopsy performed? certificate of Vital 1 □ Yes 2 No 2 🗆 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 No the f 2 Accident after death 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20+1 D53367 February 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D.P.C., 9801 Georgia Avenue, Suite 117, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2009 parked Registrar

05422

1:06pM

3. Time of Death

10d. Inside City Limits

Afro-

Approximate Interval Between Onset and Death

Day

23e. Did tobacco use contribute to the cause of death?

24a. Was an

20785

autopsy perform

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Year

XXYes 2 No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Eleanor Better Feb. 1. Year 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea **Funeral** Days Hours Months 1 □ M 2**X** F 578-60-7381 89 Director 1919 Washington DC Aug. 10, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f show event, the Medical Examiner must be notified at DC Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with 1 leath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or ' 5550 Chillum Place, NE 20011 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Yes Give Specify. A merican 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Passport Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Odell Javins Dorothy Quander Item 27 Is marke other traumatic ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Robert O. Better 9338 Gentle Folk, Columbia, MD permit. Pages 1 ar Department of Her Important: If Item any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/2009 Washington DC Mount Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MCGuire Funeral Service, Inc. 21. Signature of Funefal Service Licensee Indre Thompson 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus (Type II) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hypertension Due to (or as a consequence of) Physician/Medical Anemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No 5 Other (specify)

Box 68760. P.O. of Vital Records. After Division

page 2 s funeral

Hospital or Attending Physiclan: The law requires that the death certificate be executed ours after death.

neral Director: A
filled in by the fu

Completed by Be Certification: To

Medical

within 24 hours a

To the Funeral I

24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, MD

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dr. Gary Little

31. Date filed (Month, Day, Year) FEB 0 5 2009

Registrar's Signature

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SUSAN ELIZABETH BRANNAN Feb. 2009 3:03 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Stella Maris Hospice Baltimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12/4/195 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Days Hours 51 219-78-8115 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examinar must be northlise at Director 1 ☐ Yes 2 X No MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1150 Chrome Hill Road "natural", or items 23a 21084 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 N Ho Specify ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Special Needs permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Jackson မ Arthur Hart Etta Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) 1150 Chrome Hill RD. Garry L. Brannan (Husband) Jarrettsville, MD. 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 2/21/2009 Hampstead, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral 1. Sudden Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) END STAGE LIVER DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month 4 Pregnant at time of death 5 Other (specify) P.O. I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times$ Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation Division 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

X Nurse Practitemer stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2/16/2009 K157624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JENNIFER HAUF, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DX

3:03 р.п.

FEBRUARY

SUSAN BRANNAN

			For State Registrar	State of	f Marylan		artment rtificate			and M	•	giene Reg. No.	2009	05424
4	Physici /Medic	_	1. Decedent's Name (First, Middle Juanita Virgini								2. Date of De Month 2/6/20	Day	Year	3. Time of Death 8:30 P ^M
	Examin		4a. Facility Name (If not institution Clinton Nursing	, give street and nur	nber)		,	rown, or .n t or	Location o	f Death			County of Death ince Geo	rge's
	Funeral Director		5. Social Security Number 579–48–2396	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 75	Vrc	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 9/11/	ay, Year)	Coun	lace (State or Foreign try) ngton, DC
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show propriant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 6702 Tiara County 11. Marital Status	12. Was Dece	Cli	10c. City, Town or Location Clinton 10f. Zip Code 20735 Int Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica								S an Indian,
15-0036	n 72 hours after "natural", or its edical Examine	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced 15. Deceden (Specify only highe		² No	16a. Dece	1 ☐ Yes 2 dent's Usua kind of wor	No No	Specify: ation				Black, White, Specify: Blac	k
Maryland 2121	be filed withir ntat Hygiene. ed other than event, the Me	Be Completed	Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle,	College (1	-4or 5+)		ekeepe		St. I	r's Name	abeth (First, Middle	, Maiden	. Govern Surname)	ment
Maryla	d 2 should Ith and Men 7 is market traumatic		Robert Johnson 19a. Informant's Name/Relations	, , , ,		1			and Numbe	er or Rura		er, City or	Town, State, Zip	Code)
altimore, l	Pages 1 and 2 nent of Health int: If Item 27 inty or other tra		Howard Carter S1 20a. Method of Disposition 1★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from	State	Place of Disponentery, cre	osition (Nan matory or o	ne of ther plac	e)		Maryl	20c. Loc	cation - City or To	
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		Mos		2. Name an	d Addres	ss of Facilit	Alex	ander S	S. Po	pe Funer	al Home
	Physician	(F)	23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that of only one cause on e	aused the deat ach line.		_				or respiratory a			Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to in include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	or as a consequence of as a consequence of as a consequence of as a consequence of a conseq	uence of): uence of):								
P.O. Box 6	v requires that the death certifica been signed by the attending pl should be detached for use as t	ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live b	tcome pf pregna birth 2 □ Feta nant at time of d own	al death 3	⊒Ectopic pr ⊒ Other (sp		′			2	23d. Date of delive Month	ery Day Year
	quires that in signed build be deta	by	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	underlying ca	ause giv	en in Part 1.				se contribute to tl ☐ No 3 ☐ Prot	ne cause of death?
al Reco	iclan: The law requir certificate has been si rector, page 2 should I	Completed									24a. Was auto perf 1∐ Yes		24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2□ No
Division or Vital Records,	ding Phys n. After this funeral dii	Certification: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 28a. Date (Mon gation not be larged) 28e. Place		28b. Time of Injury	of 2	8c. Injur Wor 1 🗆	er: 4 🗷 Nu	nrsing Ho	28d. Describe	idence 6 how injury	d Number or Rura	
Ö	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medical	ng Physician: To the	e best of my kno	owledge, dea					and due to the	cause(s)	and manner as s	
,	To the P within 24 To the F	Medical	29b. Signature and title of certifie	and man	ner stated.		290	. Licens	e number			29d. Date	e signed (Month,	Day, Year)
R	5 Sta	ate	30. Name and address of person Nichale (Silo) 31. Date filed (Month, Day, Year,	who completed cause	se of death (Iter	7 23a) (Type	, Print)	5 St	on No	1#	(o), f+	W1!	slingto	L 107076

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 200°2 **Month** 23PM **Physician** EB /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner DSPITA AUTINORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🖫 F 59 July 7, 1949 220-54-4695 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State er than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25 Georgetown Road 21793 United Funeral States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wholesale al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Distributor Co. Clerical alth and Mental Hygir 27 is marked other r traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be G. Merhl Cramer Thelma Fogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cramer / Sister 25 Georgetown Rd./ Walkersville, Maryland 21793 Κ. Yvonne 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/3/2009 Frederick, Maryland Stauffer Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 40 Fulton Ave. / Walkersville, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) un **Physician** /Medical Duesto (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a o 9 ☐ Unknown 9 Unknown تَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 s page eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **HN**0 To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referre o medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BACTIMONE ND 21202 NA 301 05 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 12 1202 1

State of Maryland / Department of Health and Mental Hygieng 0.0905426 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death February Da **Physician** 1 2009 0310 Sylvenia V. Conway /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Yrs. 79 1929 Director 215-34-9157 Maryland Usual Residence of Decedent with the Maryland show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Odenton 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 10 USA 21113 or Items 23a 1372 Galloway Rd. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or tien any injury or other traumatic event, the Medical Exercities: once. 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 11th Homemaker None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John P. Williams Fannie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 673 Old Waugh Chapel Rd. Odenton, Md. Sheila Isler(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Rest Cemetery 2-5-09 Hanover, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Winame Ramser Soil Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Jarry A. Rese MOOGS 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mosen erebrus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of). as the burial-transit the death certificate be executed Exami that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has performed' 1 🗌 Yes 20 No or Attending Physician: after death. Oractor: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 Im 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04 2009 Registrar

			For State of Marylan		artment of H rtificate of I				009	05427
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	Physicia		Margaret Lee	Cot	rdell		Month Februar	Day	Year 2009	10:25 A M
i je	/Medic Examin		4a. Facility Name (If not institution, give street and number)	- 001		Location of Death	1 CDL da		nty of Death	
			CJ's Senior Care		Hagers				shingt	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Yea <i>r)</i>	Cou	place (State or Foreign intry)
	Director		215-26-8035 88 Usual Residence of Decedent	Yrs.			Jan. 6	1921	Mary	land
	land ow it			ty, Town or Lo	cation	4-48-48-4				10d. Inside City Limits
	Mary -f sho	tor	Maryland Washington Ha	gerstov	ano					1 □ Yes 2 No
	r 28a	irec	10e. Street and Number	gerstov	10f. Zip Code			10g. Citizen	of What Cou	intry?
	h witi	al D	19203 Paradise Manor Dr.		21742			U.S.A.		
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show odic I Examiner must be notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. F	Race - Ameri Black, White,	
36	or it		1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 No	Specify:			ecify:	
15-0036	hours tural"	ed by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a Decer	dent's Usual Occup	ation		16b Kind o	Wh of Business/Ir	ite
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ğ	Hyg Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle	, Maiden Suri	name)	
Maryland	uld be Mental rrked o	TO E	Leo Hedderman			Ida Mar	ie Ker	nd1e		
a	S S S	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numb	er, City or To	wn, State, Zi	ip Code)
	5 m 0 F		Rosalie Miller / Daughter	19203						yland 21742
altimore,	8 5 = 0		Negligital 2 Ucremation 3 Hemoval from State 1	cemetery, crei	sition (Name of matory or other plac	ce)	Date	20c. Locatio	on - City or T	own, State
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o.	the de	ysic	1 Yes 2 No	Jean 5L	Other (specify)					
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Records,	uires 1 sign Id be	d by	Horall Descen	2			1 🗆	Yes 27N	o 3 Prc	bably 4 Unknown
000	w require	lete		- m	Oral.	160	24a, Was	an 2	4b. Were aut	topsy findings available
	he la e has age 2	Completed	Hulph Got	Zef /	Cyster.	MICO -	auto perf	psy ormed24	prior to co death?	ompletion of cause of
Viita	nysician: The law his certificate has b director, page 2 s		25. Was case referred to medical	-1		26. Place of Deat	1 Yes		1 □ Yes	2 1 No
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0	endir ath. or: Af he fur	atio	2 Accident investigation			Yes 2 □ No				
Division or	or Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special Could not be building, etc.)		reet, factory, office		28f. Location (City or To	Street and No wn, State)	ımber or Rui	ral Route Number,
	Hospital or Attending I 44 hours after death. Funeral Director: After tely filled in by the funer		A Charles Physician Table had a family		da	data and alara	and does to the			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, F.	edical	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 1 Certifying Physician: To the best of examiner to the best o	ation and/or in	ivestigation, in my o	opinion, death occur	red at the time	, date and pla	ice, and due	to the cause(s)
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier		29c. Licens	e number		29d. Date si	gned (Month	, Day, Year)
R	->-0		I The	m)	Dan.	45031	,	Feh	10'	2009
-			30. Name and address of person who completed gause of death (Ite	m 23a) (Type,	Print)	1 0	61	1	11 -	7.2
16	H-1		S. HAMMES Z SI DOTAUL. 32	4 E	Chut	refein	8-5	PCC 1	tas	MUZITUO
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature						
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			1 - For State Registrar	tate of Maryland	-	artment of F		Mental Hy	giene Reg. No.	711111	05428
e de la companya de l		0	Negistrar Name (First, Middle, Last)			timodito or .		2. Date of D	eath		3. Time of Death
	Physicia		WILLIAM STEPHEN O	CRUTCHFIELD				Month Januar	р Дау У 19		9:28 P M
Ŋ.	/Medic Examin		4a. Facility Name (If not institution, give street	t and number)		4b. City, Town, or	r Location of Deat			County of Death	7,120 1
			Washington Adventis	st Hospital		Takoma			M	lontgome	ry
167	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)	Cou	
L	Director		Usual Residence of Decedent	60	115.			Nov. 2	, 194	8 Wash	ington, DC
	and sw		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary f sho	ō	Maryland Montgomery	Si	lver S	Spring					1 ☐ Yes 2 📉 No
	r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	th with		9116 September Lane			20901			U.	S.A.	
	ems :	Funeral	11. Marital Status	Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ameri Black, White,	
9	or it	by Fu		∏Yes 2⊠No fYes, Give		1 ☐ Yes 2 ☒ No	Specify:			Specify: B1	ack
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at inf, the Medical Examiner.	d be	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education	rear or Dates:	16a Decer	dent's Usual Occup	pation		16h Ki	nd of Business/Ir	dustry
<u>ဂ</u>	in 72	Completed	(Specify only highest grade co	mpleted)	(Give	kind of work done	durina most of wo	rking	7	er Reed	-
7 7	with jene.	E		College (1-4or 5+)	Certi	fied Publ	lic Acco	untant	Cent	er	
2	be filed within 72 hours after death with the Marylar thygiene. In atthygiene, and eithygiene an	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na		e, Maiden	Surname)	
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e, ≤	es 1 and 2 should b of Health and Ment f Item 27 Is marked ir other traumatic e		Jennifer E. Martin/			Gairlock		Lanham,			
	Pages 1 nent of H int: If Ite Iry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo	iva: from State		osition (Name of matory or other place	. 041	05/		cation - City or T	•
Baltimor	t. Pa tmen tant:	93	4 □ Donation 5 □ Other (Specify)	For		coln Crem				twood,	•
ga	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Cicensee	+	μį	NES-RINA	LDI FUNE	RAL HOM	E, IN	C.	g, MD 20904
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	Examiner				,		-				
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Š	De execian a	ĕ	resulting in death) Last	Due to (or as a consequ	uence of):						
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×	leath certific attending p	Physician/Me	IF FEMALE: 23c.	If yes, outcome pf pregna	incv					23d. Date of deliv	on.
X Q Q	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	у		1	Month	Day Year
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 J	uires that the de signed by the a id be detached f		Part II. Other significant conditions contrib	uting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to	he cause of death?
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ecords,	> 10 70	olete						24a. Wa		24b. Were aut	opsy findings available
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νпа	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only			
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<u> </u>	tendil leath. tor: A	cati	2 Accident investigation	No. Disease distance At he			Yes 2 ☐ No	2007	(2)		
MINISION	or At after d Direct in by	Certification:	4 ☐ Homicide determined	8e. Place of injury - At he building, etc. (Specify	y)	геет, тастогу, описе			(Street an own, State		al Route Number,
5	o the Hospital or Attending P. ithin 24 hours after death. o the Funeral Director: After tompletely filled in by the funera		29a. Certifier 1 Certifying Physicia	an: To the best of my kno	wledge, deat	th occurred at the ti	me, date and place	e, and due to th	e cause(s)	and manner as	stated.
T	e Hos 24 h e Fun letely	edical		On the basis of examina and manner stated.							
	To the To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Da	te signed (Month)	Day, Year)
	4		1201/_	-			6806	8	1/	19/20	>09
	· On the state of		30. Name and address of person who comp						255		
			Craig Dates, MD, 76			, Takoma	Park, M	aryland	2091	2	
70	Sta Registi		31. Date filed (Month, Day, Year) FFR 0.5 2009	22. Registrar's Signa		K.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05429 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 4, John Njoroge Chege 2009 12:29 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 30, Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Year) 1938 519-50-8628 70 Kenya Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 11526 Brundidge Terrace Kenya Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Black Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+Teacher/Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chege Wa Njoroge Esther Wanjiku Karuigi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11526 Brundidge Terrace, Germantown, Md. 20876 Chege Wa Njoroge - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/20/2009 Karuri Kiambu Cem. Kenya 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licenses Sonald 1091 Rockvillepike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14 spivation Due to (or as a consequence of): NYCHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 01 CN d 1, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1. - 1 - . D. - 11 . h . . .

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lightly or other traumatic event once.

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f shov The Medical Examinar is ust be notified at

Baltimore, Maryland 21215-0036

Directo

Funeral

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ing physician and s as the burial-trans attending physician łoł signed by the a d be detached for after death Director:

Physician/Medical þ Be ٩ Certification:

Examine

DIGDERS	Melli	603		1 ☐ Yes 2)	Ño 3□ Probably 4□ Unknow		
				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ Yo		
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 🕽	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	G ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysiclan: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)		
29b. Signature and title of certifier	1	2	29c. License number	29d. Dat	e signed (Month, Day, Year)		

DAILESWD

charibrine Germanteun MD20871

State Registrar

UFI 31. Date filed (Month, Day, Year)

FEB 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

19529

To the Hospital of within 24 hours a To the Funeral D

e of Print in black indelible ink. Ensure All Copies Are Legible.	
ate of Maryland / Department of Health and Mental Hygiene 2009	05430
Cartificate of Dooth	

			For State Registrar	State of Maryland		tificate of L			gienez Reg. No.	.003	03430
			Decedent's Name (First, Middle, La	st)				2. Date of De		Year	3. Time of Death
	Physicia /Medic		DANIEL JAM	ES COLE, SR.				Feb.		2009	2030 P M
}	Examin		4a. Facility Name (If not institution, give		4c. C						
				sing & Rehab (sbury	0.0		Wicomi	
	Funeral Director		213-20-3775	Sex 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 3(y, Year)		lace (State or Foreign etry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	0d. Inside City Limits						
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	the 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of								itry?
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	deet	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No)- 1-	4. Race - Americ Black, White,	
Mai yiaila 21210000	illed within 72 hours after deeth with the Marylan thyglene. ther then "naturel", or litere 23a or 28a-1 show int, the Macical Examiner mat he notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 41 — 4	ŀ	1 □ Yes 2 ☑ No		, , ,			ite
	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation 1	6a. Deced	dent's Usual Occupa	ation during most of work	ing	16b. Kin	d of Business/In	dustry
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4	tygier her th	ပိ	/ t h 17. Father's Name (First, Middle, Las		Cust	odian	18. Mother's Name	a /Eiret Middle			School_
	d in D	Be	Daniel Cole	<i>(</i>)			Martha			oumame)	
Š	should and Men marke umatic	은	19a. Informant's Name/Relationship	(Type Print)	19h Mailir	ng Address (Street a				Town State Zin	Code
2	2 4 7 2		Brenda L.Cole/	D 1.		Eldora			-		0115
ນົ	s 1 and f Health Item 27 other to		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place	do kilou	Date	20c. Loc	ation - City or To	
2	m 0		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Themoval nom State		rans Ce	1	1/00	Hur1	ock, M	D
baltimore,	permit. Page Department of Important: if eny Injury of once.		21. Signature of Funeral Service Lice		22	. Name and Addres	ss of Facility	1,00			
Ď	F 5 E 8		Christine	m. Coale	F	ramptom ederals	Funera burg M	l Home	, PA		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused the death. I	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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r.o. box	ath cer ttendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ery Day Year
	res thet the de signed by the a be detached f	Phy	Part II. Other significant conditions	contributing to death but not resulting	ng in the u	nderhing cause au	en in Part I	23e Did	tobacco us	se contribute to t	ne cause of death?
oras,	w requires t been signe should be	ted by									pably 4 Dunknown
Division of Vital Records,	The law rate has be	Completed						24a. Was auto perf 1 \superity		24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
<u>I</u>	artification.	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only	one)		
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	To the Hoepital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	thysician: To the best of my knowle iminer: On the basis of examination and manner stated.	edya, deat n and/or in	h occurred at the time vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	rause(s) date and	and manner as s place, and due to	lated o the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
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			30. Name and address of person who	o completed cause of death (Item 2	3a) (Type,	Print)	040 5	alich			•
	C+	ate	31. Date filed (Month, Day, Fear)	32. Pegistrar's Signatur	9,	1 7 7	712	- ' > ' V		, /	7
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DHMH 17 Rev 1/2001 ASax

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dotty Marie Deaton 1:48 A M Jan. 30, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Genesis Eldercare Severna Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F 67 240-64-8051 Director North Carolina July 06,1941 Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis Be Completed by Funeral Director 1 ☐ Yes 2 ▼ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21409 1178 St. George Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) High Point University Elementary/Secondary (0-12) College (1-4or 5+) Admission Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Keith Pooser Wylma Mae Berry ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawson A. Deaton, Jr./ Husband 1178 St. George Drive Annapolis, MD 20b. Place of Disposition (Name of Atlantic Crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Jan. Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Fyrneral Service License 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line. Immediate Cause (Final SQUAMOUS **Physician** CANCER CELL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) cate has been signed by the page 2 should be detached in 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ∐Yes 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital

Division

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

KILBLIDE RD, BATTIMORE, MD 21236 9005 ALCACE, WID Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

031136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05432 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Ye ar **Physician** 4:40 PM Feb ruary Harold Wishard Durbin 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Fahrney Keedy Nursing Home Boonsboro 8. Date of Birth Feb. 23, 1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Mary land 85 Director 219-14-9419 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov ary or other traumatic event, the Medical Examiner must be netitied at Director 1 ☐Yes 2 🔀 No Hagerstown Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 17812 College Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🕅 💢 o Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellis Durbin Samantha Corderman Elmer ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tr. once. 17423 Lappans Road Fairplay, Maryland Marlin Durbin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery Feb. 13, 2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) O'S Derene Affiner er eity Home, P.A. 21795 425 S. Conococheague St. Williamsport, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician) eventua disease or condition resulting in death) /Medical Due to (or as a consequence of) Cardiovasialar Disease Examiner exterious if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atter this certificate has been s funeral director, page 2 should is 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Records, **Division of Vital** ospital or Attending Phours after death.
neral Director: After the filled in by the funera

show

Maryland 21215-0036

altimore,

To the Hospital of within 24 hours at To the Funeral D 05H-1

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Khalid Waseem, M.D. 31. Date filed (Month, Day, Year)

FEB 11



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hagerstown, Maryland

29d. Date signed (Month, Day, Year) 02-11-2009

Holy Cross Hospital Silver S If Under 1 Year | If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **№** M 2 | F 74 Director 214-32-9188 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at Director MD Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number Items 23a or 120 Duvall Lane, #203 20877 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Menter and once. by Funeral 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trash Collector 9th 17. Father's Name (First, Middle, Last) Be Lawrence Duffin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 Renee Duffin (Daughter) 120 Duvall Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Walurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Brooke Grove Cem 2/10/09 Signature of Funeral Service Lice VA. 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): Examiner Hypercarbic
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atten death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral inverted infector, page 2 should be detached for use as the burial-transit Hypoxic Respiratory Failure Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetał death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 25. Was case referred to medical Be Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

1 Decedent's Name (First Middle Last)

CANNON

4a. Facility Name (If not institution, give street and number)

JOHN

Physician

/Medical

Examiner

DUFFIN, SR 2. Date of Death JAN 31, 2009 12 treet and number) 4b. City, Town, or Location of Death Spital Silver Spring MONTGOMERY 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Months Days Hours Min. Month Dec. 6, 1934 10c. City, Town or Location 10d. Inside	po or remain black intention in a black of the beginning										
DUFFIN, SR 2. Date of Death JAN 31, Day Day Pear JAN 31, Day Day Pear JAN 31, Day Day Pear JAN 31, Day Day Pear JAN 31, Day Day Day Pear JAN 31, Day Day Day Day Day Day Day Day Day Day	5433										
Ab. City, Town, or Location of Death Silver Spring MONTGOMERY	Time of Death										
Spital Silver Spring MONTGOMERY 10. Age (In yrs. last birthday) Age (I	12:05₽										
Table Tabl											
10c. City, Town or Location 10d. Inside	Y										
College (1-4or 5+) Caithersburg Caithersburg 10f. Zip Code 10g. Citizen of What Country? 10f. Zip Code 10g. Citizen of What Country? 10g. Citi	(State or Foreign										
10f. Zip Code 20877 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes, Give Year or Dates: 10f. Zip Code 20877 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No 1 □ Yes 2 □ No	side City Limits										
20877 2. Was Decedent Ever in U.S. A. 2. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: 20877 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: 20878 1 □ Yes 3 □ No Specify: 20879 1 □ Yes 3 □ No Specify: 20879 1 □ Yes 3 □ No Specify: 20879 1 □ Yes 2 □ No Specify: 20879 1 □ Yes 3 □ No Specify: 20879	¥Yes 2 □ No										
2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: ation completed) College (1-4or 5+) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)											
Armed Forces? 1											
If Yes, Give Year or Dates: 1 □ Yes 2 □ Yes Specify: Specify: Specify: Black ation completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	dian,										
Completed) (Give kind of work done during most of working life. DO NOT use retired)	ck										
College (1-4or 5+)	1										
The state of the s	osal										
18. Mother's Name (First, Middle, Maiden Surname)	18. Mother's Name (First, Middle, Maiden Surname)										
Ein Emma B. Thompson											

#203, Gaithersburg, MD 20c. Location - City or Town, State

Laytonsville, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A.

246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death

23d. Date of delivery Month Year Dav

> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Munknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform

death? 2 No 2**X** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year) 0068150

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd, Silver Spring, MD 20910 Nejob Salih Siraj, M.D.

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 0 6 32 Registrar's Signature

and manner stated.

			For State Registrar	State of Mar	ryiand	Cei	rtment of H rtificate of L	ieaith ai D <i>eath</i>	nd Mental	Hygie	ene 2 0	09	05431	+
			1. Decedent's Name (First, Middle, Las						2. Date	of Death	Day	Year	3. Time of Death	_
	Physicia /Medic		David	Alan Dewees	S				Februa		01	2009	3:50 ам	_
1	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or				4c. County			
, a			Holy Cross H		(In the least	A for instance of	Si1	ver Spr If Under 24	0	of Dieth			gomery	
	Funeral Director		546-30-9519	X M 2 □ F	(In yrs. las	Yrs.	Months Days		Min. (Mont		(ear) 17 , 1927		lace (State or Foreigr try) fornia	,
	and		Usual Residence of Decedent 10a. State 10b. County	11	10c. City,	Town or Lo	cation				-	11	0d. Inside City Limits	-
	Maryl f sho	tor	Maryland Montgon	10 2 7			Tako	ma Park					1 □ Yes 2₺ No	
	r 28a	Director	Maryland Montgon 10e. Street and Number	iery			10f. Zip Code	ind Tark		100	g. Citizen of \	What Coun	try?	_
	h with	al D	7051 Carroll Avenu	ıe				20912				U.S	.A.	
	ems arm	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origii n, Mexican, I	n? (Specify Yes of Puerto Rican, etc.	or No-		e - Americ		
36	should be filed within 72 hours after death with the Maryland Ind Mental Hyglene marked other than "natural", or items 23a or 28a-f show matic event, the Norlen Empired and all confiled	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ⊠Yes 2 □ No			∐Yes 2⊠No	Specify:			Specify			
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D	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, M			ne)		
<u>₹</u>	should be I and Mental s marked o numatic eve	1º		nry Dewees		401 14 15	4			ı Blad		04-4- 70-	0-4-1	_
ā ≥	12 s th ar		19a. Informant's Name/Relationship (7				g Address (Street						Coue)	
<u>ရ</u> ်	s 1 and 2 of Health Item 27 i		Daniel R. Mason - S 20a. Method of Disposition	OII	20b. Plac		tratford Ro sition (Name of natory or other place		Date Date		c. Location -		wn, State	-
<u></u>	Pages nent of int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				n Crematory	1	2/07/2009		Brentwo	od. Ma	rvland	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licent		7	. 22	. Name and Addres	s of Facility				,	- J =	_
	<u>0.0 = a o</u> i		Nancy tt.	discontinuo discontinuo di di	bo dooth		1800 New Ha					g, Mary	/land 20904 Approximate	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final											
	Physician /Medical		disease or condition resulting in death)	a. Respin		Failu	re							_
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a		nce of):								_
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68760,	ifficate be executed g physician and as the burial-transit	edical		d. Conges	stive	Heart_	Failure							_
	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal d	eath 3 □	Ectopic pregnancy Other (specify)	/		_		te of delive	ery Day Year	
<u>.</u>	that thed by detacl		Part II. Other significant conditions of	ontributing to death but	not resulti	ng in the ur	nderlying cause give	en in Part I.	23e.	Did toba	cco use cont	ribute to th	e cause of death?	_
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0	nding Physician: ath. r: After this certific: e funeral director, p	ation	1 ★ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day,	Year)	Injury	Work	yai ?? Yes 2∐No		TIDE HOW	injury occurr	eu		
Division of	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At hom (Specify)	e, farm, str	eet, factory, office		28f. Locat City o	on (Street Town,	et and Numb State)	er or Rura	Route Number,	
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	To th within To th comp	Me	29b. Signature and title of certifier	7.0			29c. License	e number	0	290	l. Date signe	d (Month, I	Day, Year)	
			DIK	chma	wice	^		006 6	572	I	February	7 2, 20	009	
	5+1		30. Name and address of person who							0007				
		to	Majid Rahmanian, M	1.D., 1500 For			ad, Silver	spring,	Maryland	2091(U			_
	Sta Registr		FEB 0 5 200		A.	bar	40							

			For State Registr <i>a</i> r	State of M	laryland	d / Depa	artment of I rtificate of	Health a Death	nd Mental	Hygien Reg. N	e 2009	05435
	Physici	an	1. Decedent's Name (First, Midd	,					2. Date of Month		ay Year	3. Time of Death
- W	/Medic	al	Jerome 4a. Facility Name (If not institution)	Allen	r)	Da	noff 4b. City, Town, o	or Logotion of			2009 C. County of Death	6:45 A M
	Examin	er	15200 Hannans		/		Rockvil		Death	40	Montgome	
	Funeral		5. Social Security Number			ast birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of	of Birth h, Day, Year 0/1939	9. Birth	place (State or Foreign ntry)
C	Director		179-50-5578 Usual Residence of Decedent	10 M 20 F	69	Yrs.		110010	07/20	7/1939	Mary.	
yland	MOI W		10a. State 10b. Count	/		, Town or Lo					1	10d. Inside City Limits
Mar Mar	Sa-f st	ctor	Maryland Mont	gomery	Roc	kville	9					1. LYes 2 □ No
	or 21	Dire	10e. Street and Number				10f. Zip Code			_	itizen of What Coul	ntry?
eath v	1s 23g	eral	15200 Hannans 11. Marital Status	12. Was Decedent	t Ever in LLS	3 13	20853	Hispanic Origi	in? (Specify Ves.	US or No-	A 14. Race - Ameri	can Indian
6 after d	or iten	Fun	1 ☐ Never Married 2 ☑ Ma	Armed Forces rried 1 □Yes 2 ∑	?	1	Was Decedent of H		Puerto Rican, etc	.)	Black, White,	etc.
5-0036 The Park and The Maryland	Eye	d by	3 Widowed 4 Divorce	If Yes, Give Year or Dates:	:		1 □Yes 2⊠ No				Specify: Wh:	
15- n 72 h	an u	Completed by Funeral Director	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	of working	16b. l	Kind of Business/In	dustry
2121 d within	giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		nacist	_/		P	harmacy	
Maryland 21215-0036	ntal hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examirat must be routified at	Be	17. Father's Name (First, Middle	, Last)					s Name (First, Mi	ddle, Maidei	n Surname)	
ryla nould t	nd Menta marked matic ev	၉	Samuel Danoff	=					sie Wolf			
Mal d 2 st	Ithan 27 isr traur	1 1	19a. Informant's Name/Relation Sheila Z. Dano			1	ng Address <i>(Street</i>) Hannans				or Town, State, Zip	o Code) 20853
star	Item other		20a. Method of Disposition	_		ace of Dispo	sition (Name of matory or other place	- ;	Date		ocation - City or To	own, State
imo Page	ment c ant: If ury or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 ☐ Removal from State Specify)	Juď	ean Me	emorial G	dns 02	2/05/2009	01n	ey, Mary	land
Baltimore,	Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic exonce.		21. Signature of Funeral Service	Licensee		22 I	Name and Addre Edward Sa 1091 Rock	ess of Facility gel Fu ville	neral Di Pike. Ro	recti	on, Inc. le. Marvi	land 20852
ecuted Ex	ysician and Medical aminer transit	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds to the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Interval Between Onset and Death 2 YEARS		
P.O. Box 68760, at the death certificate be ex	been signed by the attending pharbould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1	2 Fetal at time of de	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		_	23d. Date of deliv Month	ery Day Year
	en signed b	ğ	Part II. Other significant condit	ions contributing to death	but not resu	Iting in the u	nderlying cause giv	ven in Part I.				he cause of death? bably 4 ☐ Unknown
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Le Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 1 Certify 2 Medica	ng Physician: To the bes Examiner: On the basis and manner s	of examinat	wiedge, deat ion and/or in	h occurred at the ti vestigation, in my o	ime, date and opinion, death	place, and due to n occurred at the t	the cause(ime, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
10 10	With To th		29b. Signature and title of certifi	GO)	Ce		29c. Licens D001				ate signed (Month, bruary 3	
			30. Name and address of person Dr. Kenneth Go	· ·			,	te 707	. Wachir	oton	DC 2003	87
	Sta	te	31. Date filed (Month, Day, Year	37. Regist	trar's Signat	ure		707	, washil	.g com,	DO 2001	,,
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Please Type or Print in Black Indelible Ink. 2773 yrg All Copies Are Legible.
Amend Item 29d per phys.
State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Maureen Cecelia Durst 12:45 PM 12, *February* 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20705 Oriole Circle Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TF 212-38-5218 70 Yrs **Director** 4, Aug.1938 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 Oriole Circle 21742 U.S.A.Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Agriculture 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item ZZ Is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Michael Donahue Margaret Cecelia Lucas ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Wade Durst (Husband) 20705 Oriole Circle Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Smithsburg Crematory Smithsburg, Maryland 18, 2009 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 I Unknown 9 Unknow cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home S Residence 6 Other (Specify) Hospital: 1☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ion: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after deau. ral Director: Aft Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Certificat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) February 13, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 32. Registrar's Signature Ďау, State FEB 2 Registrar

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920	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the "Adical Evani her must be notthed at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		i	f Yes, specify	/ Cuba	ispanic Origin: n, Mexican, Pi Specify:	r (Specin uerto Ric	an, etc.)	VO-	Specify:	White,	etc.	
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ords	w requires s been sign should be	ed b									_	1 🗆	Yes	2 □ No 3	☐ Prob	ably 4	X Unknown
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	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	y sician : To the best nIner: On the basis o and manner st	of examination	dge, death and/or in	n occurred at vestigation, i	the tin	ne, date and p pinion, death o	lace, and occurred	d due to th at the tim	ne cause e, date a	e(s) and man and place, an	ner as s d due to	tated. the cause	e(s)
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			Jocelyn	e Kouatch	nou, MD	6001	Munca		Mil	l Road,	, Roo	ckvil	lle,	MD 20	855		
	Sta Registr		31. Date filed (Mon	th, Day, Year) EB 0 5 20		ar's Signature	ba	News.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2/3/2009 3:34 p.M GENE MAURICE FUELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forestville Health & Rehab. Forestville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 113 M 2 □ F 6/26/1937 Director 578**-**48-6332 71 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifiled at 1 X Yes 2 □ No Director Maryland | Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7324 Donnell Place # B1 20747 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. iled within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Specify: Black 3 □ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Glazer Private permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygis
Important: If Item 27 Is marked other
any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Saunders Earl Fuell Geneva Derr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella J. Fuell / Wife 7324 Donnell Pl. #Bl Forestville, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/7/2009 Harmony Memorial Landover, Maryland Name and Address of FacilityPope Funeral Homes, P.A. 21. Signatur of Funeral Service Licenses Marys 5538 Marlboro Pike Forestville, Maryland 20747 Int. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** HEPATIC ENCEPHALOPATHY resulting in death) /Medical Due to (or as a consequence of) Examiner ALCOHOLIC LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2♥ No CORONARY ARTERY DISEASE autopsy performed' 1∐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospitai or 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19889 2/5/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaime Botello MD 1328 Southern Ave. S.E. Washington, D.C. 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene

2009 05439

		1- For State Registrar	Ce	rtificate of De	ath	Re	g. No.	3 0040
Physicia ledical Exami	an/	Decedent's Name (First, Middle,Last)	1 1	Lisa	Francois	2. Date of Death	Day Year	3, Time of Death
Tedical Examin	nei	Fisa (hery)	HIA	Trancio	-	February 7	, 2009	1535 hrs
		4a. Facility Name (if not institution, give I-95 SB Mile Marker 80.3	street and number)		ty, Town, or Location of Dea Icamp	tn .	4c. County of Deat Harford	h
Funeral		5. Social Security Number 6: Sex	7. Age (In yrs.	last birthday) If I	Inder 1 Year If Under 24H	rs. 8. Date of Birt	h(MM/DD/YYYY) 9. Bi	
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Varyland 28a-f show d at once.	ctor	10e. Street and Number		100K/41	Zip Code	10	g. Citizen of What Cou	
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nore, MD 2121 ages I and 2 should be fi nt of Health and Mental I tt: If item 27 is marked other traumatic event,		20a. Method of Disposition		Place of Disposition (Date	20c. Location - City of	Town, State
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 njury or other traun		1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	crematory or other pla	2/	20/09	Brokling	1/4
Baltime bermit. Page Department Important:		21. Signature of Funeral Service Licens	ee //	22. Name	and Address of Facility	Steven	LeGall For	real Home
		-told W. Kill		169	EMPIRE Blad.	Brook /41	1 New York	11225
Physician /Medical		23a. Part I. Enter the disease, or compli- failure. List only one cause on each	cations that caused the death n line.	. Do not enter the mo	de of dying, such as cardido	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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To the How within 24 h	Medical	one) 2 Medical Examiner:	 To the best of my knowled the basis of examination a 					
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3		and			O.C.M.E.		February 8, 2009	9
2	ŀ	30. Name and address of person who co		23a)				
					, Baltimore, MD 2120)1		
Sta	ate rar	31. Date filed (Month, Day, Year) FFR 1 0 2009	32. Registrar's Signatu	ire				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 Per FH G889 3/16/09 Jh State of Maryland / Department of Health and Mental Hygiene () 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Oscar Philmore Flook, Jr. 10:15 AM 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 310 Ninth Avenue Brunswick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year June 21 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1934 213-32-7730 74 Brunswick, MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show Itam 27 is marked other than "natural", or itams 23e or 28e-f shov other treumatic event, the Modical Examinar must be notified at Brunswick MD Frederick 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 USA 310 Ninth Avenue deeth Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or ita Iry or other treumatic event, the Modical Examina. 1 XYes 2 No If Yes, Give Year or Dates: Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Frederick County School Elementary/Secondary (0-12) College (1-4or 5+) Board 10 Janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernie Laura Wenner Oscar Philmore Flook, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 49, Rohrersville, MD 21779 Robin Flook-Bowers, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 20a. Wethold of Disposition

1 ⊠ Byfal 2 □ Crymation 3 □ Removal from State
4 □ gonation 5 f Other (Specify)

21. Singal trivio(Fpy) and the first of the state permit. Page Department of Important: If any injury or once. Park Heights Cemetery 2/6/09 Brunswick, MD 22. Name and Address of Facility
John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OKONAMY SCAJE **Physician** yean disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 Yes 2 No peeu Obstruction Palmoney 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes or Attending Physiclen: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation efter death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier 122037 5/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Iciniand 610 NINTH

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Frank J. Farese <u>6:00</u>am[™] 1/29/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing Home Crownsville r 1 Year | If Under 24 Hrs. Anne Arunde1 8. Date of Birth (Month, Day, Year) 5/12/1914 Birthplace (State or Foreign Country)
 NY Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Months Days Min 94 Director 112-07-8023 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐No Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1454 Fairfield Loop Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coat Supplier Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Farese ၉ Angelina Prezioso 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Simms Landing RD. Crownsville, MD 21032 of Disposition (Name of Date 20c. Location - City or Town, State <u>Rita Farese</u> Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/2/09 Southland Cemetery | west columns, 50 West Columbia, SC 21. Signature of Funeral Service L with 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation filled in by the f 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of persor no completed cause Julyay Sw alen Byone MD21061 Registrar's Signature 31. Date filed (Mc nth, Day, State Registrar

051.1.2

Physician
/Medical
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Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	 State Registrar 			Cer	tificate of	Death	•		Reg.	No. C	JU:	3	03442
	1. Decedent's Name (First, Midd	fle, Last)		_				2. Date of De Month	eath	Day	Year	3.	Time of Death
an :al	Anne S. Flight								1/2	2009	TO COL		3:45pm ^M
er	4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town,	or Location	of Death			4c. County	of Deat	th	
	Ginger Cove					apoli				Anne	e Ar	unde	<u> </u>
	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Day		r 24 Hrs. Min.	8. Date of Bi (Month, D	rth	ar)	9. Birt	thplace untry)	(State or Foreign
	229-48-0084	1 □ M 2 🙀 F	7.	5 Yrs.	MOTHITS Day	riours	IVIIII.	2/7/1				VA	
	Usual Residence of Decedent												
_	10a. State 10b. County	у		y, Town or Lo									nside City Limits
Sch	MD Anne	e Arundel	An	napoli	S							1	☐Yes 2½ No
Completed by Funeral Director	10e. Street and Number 6105 River Cres	scent DR			10f. Zip Code	21	401		10g.	Citizen of \		untry?	
era			edent Ever in U.	C 112 1	Vas Decedent of			noifu Von or N	0		e - Ame	ricon In	dian
5	11. Marital Status 1 □ Never Married 2 → Ma	Armed Fo	rces?		Yes, specify Cu	ban, Mexica	n, Puerto	Rican, etc.)	•		ck, White		diari,
by	3 ☐ Widowed 4 ☐ Divorce	I ITYES, GI	ve	1	□Yes 2□N	Specify	<i>'</i> :			Specif	y:	Whit	:e
eted	15. Decede	nt's Education est grade completed)		16a. Deced	lent's Usual Occ kind of work don	upation	st of worki	'na	16b	. Kind of B	usiness/	Industry	1
mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	<i>nonuse retii</i> maker	ed)		9		Own Ho	amo.		
ပိ	17. Father's Name (First, Middle	(act)		Home	liaker	19 Moth	or's Name	(First, Middle	1				
Be	William P. Ste							. Russe		uen Suman	16)		
7	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailin	g Address (Stre	et end Numb	per or Rur	al Route Numb	ber, C	ity or Town,	State, 2	Zip Code	e)
	John William Fi	light Sp	ouse	6105	River Cı	escen	t Dr	. Anna	ро.	lis, N	1D 2	1401	Ĺ
	20a. Method of Disposition 1 ☐ Burial 2 € Cremation	2 Domoval from	20b. P	lace of Dispo: emetery, cren	sition (Name of natory or other p	ace)	С	Date	200	. Location -	City or	Town, S	State
	4 Donation 5 Other (At1		Cremato		2/4/2			en Bur			
	21. Signature of Fundal Solving	Licensee		1	Name and Add	ress of Facil	^{ity} Harα Δι	desty F nnapoli	une	eral H	Home	, P.	. A •
	23a. Part 1. Enter the disease, o	or complications that of	caused the death								1401	Appr	roximate
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	disease or condition resulting in death)	a. Due to	or as a consequ		-	2 1/ 10						4	V(\(\)
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/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):	hepa	ナノム	,'5					2)	rears
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O	25. Was case referred to medica	al				26 Plac	e of Death	1 ☐ Yes		No	1 🔲 Yes	2 🗆 1	No
	examiner? 1 ☐ Yes 2 Z No	Hospital:	Inpatient 2	FR/Outnatien	t 3 🗆 DOA	O		me 5 ☐ Res		6 🗆 Oth	or /Caa	- 16 .)	
ı.T	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. In	ury at		28d. Describe				ciry)	
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fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At ho	me, farm, stre	et, factory, office	1		28f. Location			er or Ru	ıral Rou	ite Number,
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Medical Certification: To	29a. Certifier Certifyi (Check only one)	ing Physician: To the	best of my kno basis of examina ner stated.	wledge, death tion and/or in	occurred at the restigation, in my	time, date a opinion, de	ind place, ath occurr	and due to the red at the time	e caus , date	se(s) and mand place,	anner as and due	s stated.	cause(s)
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te	31. Date filed (Month, Day, Year	3 2009 3	egistrar's Signa	I L	.4.1								

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Ę	Examin	lei	3625 Solomons Island I	· ·	Harwood		Anne Aruno	l el
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □	7. Age (In yrs. last birthday) F 89 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		g. Birth Cour 19 Indi	place (State or Foreign
			Usual Residence of Decedent			NOV . 2 , 1 9	19 11101	ana
	irylan show	_	10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Ba-f s	ecto	Maryland Anne Arundel	Harwood				1 □ Yes 2 No
	with t	Funeral Director	10e. Street and Number 3625 Solomons Island R	a a d	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	leath	era	11 Marital Status 12 Was I	Decedent Ever in LLS 13 \	20776 Vas Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - Americ	an Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinatic user be notified at once.	by	1 ☐ Never Married 2 Married 1 ☐ Yes	es 2010 No	Vas Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Puei ☐ Yes 2 ☐ No Specify:	rto Rican, etc.)	Black, White, Specify: Whi	etc.
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Maryland	shoul ind M i marl umati	To	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and Number or R			Code)
	and 2 ealth a 127 ls		Rose Mary Fridrich/Wif	Į.	Solomons Island			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of Dispos			c. Location - City or To	
Baltimore,	Pages tment of I tant: If ite		4 □ Donation 5 □ Other (Specify)	Lakemont	Mem. Gardens 2/5		avidsonvill	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee		. Name and Address of Facility GE			
			23a. Part 1. Enter the disease, or complications the					Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-VAG LANW			-,	Interval Between Onset and Death
4	Examiner		Due	to (or as a consequence of):				
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8760,	ficate be executed physician and s the burial-transit	E E	resulting in death) Last Due	to (or as a consequence of):				
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<u>=</u>	Physician: The la r this certificate har ral director, page 2	Con				performe	dy death? No 1 ☐ Yes	
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Division	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Certification:	2 Could not be	ace of Injury - At home, farm, stre uilding, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
_	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical C	(Check only) P Medical Examiner: On the	the best of my knowledge, death the basis of examination and/or invalent	occurred at the time, date and plac estigation, in my opinion, death occ	Le, and due to the cau urred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and file of certifier		29c. License number	29d	. Date signed (Month, i	Day, Year)
	re)		0	065272		2/2/09	
_	62		30 Name and address of person who completed of				\^-	
	` \		31. Date filed (Month, Day, Year) 32	C. Registrar's Signature	K KO HO	U.b.117 1	V19 214	V ⁱ
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01207 State of Maryland / Department of Health and Mental Hygiene Jayden Anthony Fields 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 10, 2009 0610 hrs **Medical Examiner** Jayden Anthony Fields 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Hagerstown Washington Washington County Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreign Maryland Months Days Hours Director 216-83-7579 Nov. 25.2008 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location 10b. County 10a State Yes 2 XNo Maryland Washington Hagerstown 28a-f show the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 11211 JFK Dr. Apt. 207 U.S.A. with 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Armed Forces? Married 2 X No Yes Specify: White f Yes. Give Year 1 Yes 2 X No specify: after Widowed Divorced 5 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036
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Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natt
injury by other fraumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephanie Wright Be Christian Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephanie Wright-mother 11211 JFK Dr. Apt. 207 Hagerstown, MD 21742 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 2-15-2009 Smithsburg, Maryland Smithsburg Crematory Donation 5 Other Specify. 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown,MD 21742 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on /Medical Death Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, perME, g890 4/28/09 TT X UNPENDED IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy . Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 V Yes 26 Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: Hospital: DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: unk Natura 5 Pending Fd 2/10/09 Fd 5:20 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11211 John F. Kenne Dr. #207 Hagerstown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide Kennedy found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

arked Ropera

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 11, 2009

and manner stated

Assistant Medical Examiner

32. Registrars Signature

Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

State

Registra

	1-	For State Registrar	State of Ma		epartment of He Certificate of De			g. No.	09 051	14		
cian		Decedent's Name (First, Middle, L		Silbert			2. Date of Death		3. Time of 2 of 9 2:	of Death		
lical iner	4a.	Facility Name (If not institution, g	give street and number)		4b. City, Town, or Lo	ocation of Death		4c. Count	y of Death			
		Shady Grove	Adventist	Hospit	al Rockvi	lle		Mon	ntgomery			
l r		Social Security Number 6.	.Sex 7.Age 1☐M 212 F	(In yrs. last birtl		f Under 24 Hrs. Hours Min. 50	8. Date of Birth (Month, Day, 02/07/	Year) 2009	9. Birthplace (State Country) Marylan	-		
	-	ual Residence of Decedent a. State 10b. County		10c. City, Town	or Location				10d. Inside 0	ity Lir		
_	100		000000	•	er Spring				1 ⊈Yes	,		
55		MD Montg	omery	211/								
Funeral Director		a. Street and Number 62 Colony Rd	. Apt.E		10f. Zip Code 209	03		US	What Country?			
le l	11.	Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of Hisp If Yes, specify Cuban, 	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - American Indian, ack, White, etc.			
₽		Married 2 Married 3 Widowed 4 Divorced				Specify:		Specify: Black				
Completed		15. Decedent's (Specify only highest of	Education		Decedent's Usual Occupation (Give kind of work done dur	ork done during most of working			usiness/Industry			
횰	1	Elementary/Secondary (0-12)	College (1-4or 5+		life. DO NOT use retired)	•						
5		0			None			No	one			
Be (Father's Name (First, Middle, La			11	B. Mother's Name		faiden Sumai	me)			
2	Michael Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	1							-				
1	T	healisha Mus	e / Mother	16	2 Colony Ro	d Apt.E	, Silv	er Sp	ring, MD	20		
	208	a. Method of Disposition	Domeyal from State	20b. Place of cemetery	Disposition (Name of v, crematory or other place)		ate 2	Oc. Location	- City or Town, State			
	-	1. Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cifv)	Famil	y Cemetery	2/10	/09	Louis	a County,	V		
		4 Donation o Dono (opo			y cemetery							
ġ	21	. Signature of Funeral Service Lig			22. Name and Address				tuary Inc			
	21					of Facility Un	iversa	l Mor	-			
N N N N N N N N N N N N N N N N N N N		Signature of Funeral Service Lie	wasten mplications that caused to	he death. Do n	22. Name and Address 411 Kenned	of Facility Un dy St N	iversa W, Was	l Mor	on, DC 20	0 1		
KIRE	23 Im	Signature of Funeral Service Lia A Part 1. Enter the disease, or co shock, or heart failure. List on imediate Cause (Final	ensee Warten emplications that caused to live one cause on each line	he death. Do n	22. Name and Address 411 Kenned ot enter the mode of dying,	of Facility Undy St N such as cardiac o	iversa W, Was	l Mor	on, DC 20	01 te		
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Physician/Medical Examiner	23 Im dis res	Signature of Funeral Service Lia Ba. Part 1. Enter the disease, or co shock, or heart failure. List on imediate Cause (Final sease or condition sulting in death) Inquentially list conditions, any, leading to immediate use (Disease or injury at initiated events sulting in death) Last FEMALE: b. Was decedent pregnant in the past 12 months? 1	bensee Warlan complications that caused in the cause on each line a	the death. Do note. REME consequence of consequence of consequence of the pregnancy of the	22. Name and Address 411 Kenned of enter the mode of dying, PREMATURE off): 3 Ectopic pregnancy 5 Other (specify)	of Facility Un	iversa W, Was respiratory arre	23d. Di Macco use con s 22 No	ate of delivery onth Day	Year death		

To the Hospital or Atlending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atlending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

3 Suicide 4 Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifie

27. Manner of Death 1 Natural

2 Accident

1 ☐ Yes 2X No

5 Pending investigation 6 Could not be determined

Hospital: 1 XInpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D28112

29d. Date signed (Month, Day, Year)

30. Name and address of person who was ted cause of death (Item 23a) (Type, Print)

DAVID GROSSMAN, MD., 9901 MEDICAL CENTEL DRIVE, ROCKVILLE, MARYLAND 20850

31. Date filed (Month, Day, Year)

See 10 2009 August 15 Signature

State Registrar

Medical Certification; To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 05446 For State Registrar Amended #7 per FH FCHD JLV Certificate of Death 02/05/2009Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Physician Mary Kraft Gorelick 2009 10:10 Pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F 391-22-0960 85 84 Yrs. Director 1924 Sept. 6, Wisconsin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exercites must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6139 Jefferson Blvd. 21703 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Ş Q Specify: White Specify: 3 ★ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphons Kraft Lena **Niehus** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gorelick / Son 5910 Jefferson Blvd./ Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory 01/31/2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death enal Physician /Medical Due to (or as a consequence of): Examiner on gostive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Vear 5 ☐ Other (specify) 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 INO 1 ☐ Yes 3 Probably 4 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a. Certifier 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D09689 4/54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, Jr. / 300 W. Ninth St./ Frederick, Maryland 21701 Α. 31. Date filed (Month Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 05447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Margaret Duval Gruver February 3, 21:35 P^M 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Days Hours 90 579-<u>10-0622</u> January 1. 1919 District of Columbia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. 230 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Walker Duval Mary Young Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Gruver / Son P.O. Box 1060, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/05/2009 | Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown Dav Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760 signed by the a Division or Vital Records, peen this certificate has ral director, page 2 funeral After or Attending

r death.

within 24 hours after death

To the Funeral Director;
completely filled in by the

Medical

Physician

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shovedical Examiner must be notified at

the Medical

2 should be filed within 72 hours after cand Mental Hygiene.
is marked other than "natural", or iter

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event,

Physician

/Medical

Examiner

Examine

3altimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

/Medical

Physician/Medical Completed by Be P Certification:

27. Manner of Death 1 Natural 2 ☐ Accident

5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title Af certifier wear

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alvert Memorial

31. Date filed (Month, Day, Year) 32. Registrar's Signature

2009

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Libby GORDON 2009 /Medical February 4:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Mar I If Under 24 Hrs. Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Young) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Min. Months Hours 579-20-4674 86 ithuania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🌠 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 904 Clintwood Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 📉 No Specify: 2 3X☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Liquor Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Band Jacob Dall ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6416 Prestwick Drive, Clarksville, MD Howard Gordon, Son 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 02/08/09 Olney, MD Furtir Service Licensee Tổrkninsky shebyew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstructive Airways Disease Years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 🎾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Atherosclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **∑**(No 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

be executed burial-transit 68760 attending physician for use as the burial that the death certificate Box signed by the a Ö Récords, page 2 should a certificate Vital Physician: director, Division of V After th funeral e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the feletly filled in by the funera

Funeral

Director

show

d other than "natural", or Items 23a or 28a-f shore

Hygiene.

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th

permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other:

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID ate filed (Month, Bay, 32. Registrar's Signature Year) FEB 06

Registrar

4 Homicide

e Funeral

To the within 2

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completely

Please Type or Print in Black Indeligies by Jansure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 05449 Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20°0°9 GIBSON, 26, 8:47 AM PHILLIP EARNEST JAN SR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE **GEORGES** Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2□ F 81 19,1927 Maryland Director 722-12-3461 July Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Anne Arundel Laurel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ō 23a 20724 U.S.A. 198 & Racetrack Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ➡No Specify: Black 3 ☑ Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Horseman/Groomsman Race Track 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Gibson Henrietta Robinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7615 Washington Blvd, Elkridge, MD 21075 Phillip E. Gibson, Jr (Sdn) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 permit. Pages
Department of
Important: If It
any Injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Zion Church Cem 2/6/09 Laurel, MD 21/Signature of Funeral Service/Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Stroke with Right Sided Hemiplasia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any final ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Dinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □No 1 ☐ Yes 2000 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1

✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. Ö Division of Vital I or Attending Pafter death. filled in by the Director To the Hospital o within 24 hours aff to the Funeral Di completely filled in

the Maryland

3altimore, Maryland 21215-0036

3(3

Medical

(Check only

29b. Signature and title of pertifier

State Registrar

DHMH 17 Rev 1/2001

Columbia, MD M.D. 10724 Little Pstuxent Pkwy, <u>Shahab Bávani</u> 32 Registrar's Signature FEB 06 2009

20

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64874

29d. Date signed (Month, Day, Year)

1/26/09

09-01261 Julie Giles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certif	ment of Health and Mental Hyglen Ficate of Death	Reg. No. 2009 0545
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) Julie Dove Giles		of Death h Day Year ruary 11, 2009 3. Time of Death 2205 hrs
, ~ ~ ~ ~	Facility Name (if not institution, give street and number) 6610 Cockerille Avenue	4b. City, Town, or Location of Death Takoma Park	4c. County of Death Montgomery
Funeral Director	5. Social Security Number 239-02-4022 6. Sex 7. Age (In yrs. last 1 M 2x F 47	Months Dave Hours Min	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign N.C.
show any ncc.	Usual Residence of Decedent 10a. State	wn or Location Takoma Park	10d. Inside City Limits 1 Yes 2 XNo
n the Maryland 3a or 28a-f sho otified at once.	10e. Street and Number 6610 Cockerille Avenue	10f. Zip Code 20912	10g. Citizen of What Country? USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "matural", or items 23a or 28a-f she marked other than "matural", or items 23a or 28a-f she marite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e 1 Yes 2 X No specify:	
5-0036 ed within 72 hours a stygiene. other than "natura ine Medical Examir	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Veterinarian	e 16b. Kind of Business/Industry Medical
21215-0036 uld be filed within 7 Mental Hygiene. marked other than t event, the Medica	17. Father's Name (First, Middle, Last) Jacob Giles	18.Mother's Name (First, M Alice Pugh	diddle, Maiden Surname)
그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그	Carolyn Guthrie/Partner 20a. Method of Disposition 20b. Place	19b. Mailing Address (Street and Number or Rural Rot 6610 Cockerille Avenue, ce of Disposition (Name of cemetery, natory or other place) Feb. 1	Takoma Park, MD 20912
Baltimore, permit Pages I ar Department of Her Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	opolitan Crematory 2009 22. Name and Address of Facility Francis J. Collins Fu	Alexandria, Virginia
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease a. Carbon monoxide)	500 University Blvd.,	W, Silver Spring, MD 209
recuted and transit	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
K 68760, certificate be exending physician use as the burial cian/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy	TT 23d. Date of delivery Month Day Year
cords, P.O. Box law requires that the deat has been signed by the att 2.2 should be detached for mpleted by Physi	Part II. Other significant conditions contributing to death but not result	1	e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown a. Was an 24b. Were autopsy findings available
Vital Records, sicion: The law required his certificate has been significator, page 2 should be be Completed.	25. Was case referred to medical		autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No
n of Vital ding Physician After this certi funeral directo on: To Be	examiner? Hospital: 1 Inpatient 2 ER 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28	VOutpatient 3 DOA Other Nursing Home b. Time of Injury 28c. Injury at Work? 28d. De CAT	
Division o spiral or Attending rours after death. neral Director: Aft filled in by the fune Certification:	3 X Suicide 6 Could not be 28e. Place of Injury - At home	d 9:55 pm 1 Yes 2 X No fum. e, farm, street, factory, office building, etc. 28f. Loc	_
Go the Hospi within 24 hour To the Funer Completely fil	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	death occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time.	he cause(s) and manner as stated. e, date and place, and due to the cause(s)
5-PEND \$	29b. Signature and title of certifier Tune La Deutheell, Ma	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 12, 2009
State	30. Name and address of person who completed cause of death (Item 23: Pamela E. Southall, MD Assistant Medical Examin 31. Date filed (Month, Day, Year) Registrar's Signature		201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05451 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 4, 2009 a 6:40 A M Sarah GRODJESK 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug. 23, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1914 1 □ M 2√□ F 94 143-09-3482 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 □ No Potomac Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 United States 7605 Glackens Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes A 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: white Specify 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Glass Rebecca Widetsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7605 Glackens Drive. Potomac, MD 20854 19a. Informant's Name/Relationship (Type. Print) 7605 Glackens Drive, Potomac, MD Anita Kallfelz, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 01/06/09 Olney, MD 21. Signature of cure al S Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Pulmonary Fibrosis disease or condition resulting in death) Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Renal Failure Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No

Physician / /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

28a-f show

death with

Director

2

Completed

Be

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? Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Evanainer must be notified at

2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iten

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any linjury or other traumatic events.

Baltimore, Maryland 21215-0036

/Medical

Examiner attending physician and for use as the burial-transit Physician/Medical cate has been signed by the page 2 should be detached ۾ Completed director, Be Certification: To this funeral After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 XNo 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Jocelyne

26. Place of Death (Check only one)

Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{M}$ Other (Specify) Hospice 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 10063748 29d. Date signed (Month, Day, Year) February 4, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

KOUATCHOU

Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 5 2009

5 Pending investigation

6 ☐ Could not be



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

To the within 2 To the F

			1- State of Maryland Department of Health and No. 1 - Sta	lental Hygie	en@ () (9	0545	2
	Dhariat		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	V	3. Time of Dea	ath
	Physici /Medic		Fred Albert Gaylor	February	10 2	009	1417	M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County			
			12318 Walnut Point Rd: West Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Wa	shing		
	Funeral Director		218-38-2149 11XM 2 F 68 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Aug. 26,	1940	9. Birthp Coun Ma	ace (State or Foi try) ryland	reign
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Lin	mits
	Mary -f sh	to	Maryland Washington Hagerstown				1 ☐ Yes 2X) (\0
	r 28e	Directo	10e. Street and Number 10f. Zip Code	100	g. Citizen of V	Vhat Coun	try?	
	th wit	aiD	12318 Walnut Point Rd. West 21740			USA		
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ k, White,		
36	s afte , or if	Ϋ́F	1 □ Never Married 2 1 Married 1 □ Yes 2 1 No 1 □ Yes 2 1 No Specify:	, ,	Specify			
Ş	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show the Medical Examiner must be notified at	Completed by Funeral	Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	ib. Kind of Bu		ite	
15	nin 72 n "ne	plet	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	b. Kind of bu	2111922/1110	ustry	
212	d with	mo:	Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/operator		con	struc	tion:	
b	e file al Hyg r othe	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	iden Surnam	e)		-
<u>X</u>	Ment Ment arked arice	10	711801111017111007101	ne Marie				
Maryland 21215-0036	nd 2 sh aith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 19d. L. Gaylor - Wife 12318 Walnut Point Rd.					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "netural; or items 23e or 28e-f show any injury or other traumatic event, It & Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cremationy 3 □ Removal from State	Date 20	c. Location -	City or To	wn, State	
Ξ̈́	it. Pa irtmer irtant njury		*4 Donation 5 Other (Specific) Cedar Lawn Mem. Park Feb. 21. Signature of Fungral Service Lifensee 22. Name and Address of Eacility Light		agerst	own,	Marylan	d
Ba	Depa Impo any i		Usborne runeral noi		111.000		MO 217	G.F.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or he in failure. List only one cause on each line.			por i ,	Approximate Interval Between	
8760,	Physician /Medical Examiner physician and physician and the prujal-itansit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Self Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	woun	a)	A	prex 2 h	175.
O. Box 6	death certifi e attending j d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	of deliver	y Day Year	
S, P	as the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		ale:		cause of death?	
Ö	w require been signature should b	etec	CVIT 20 yrs ago	1 ☐ Yes	2 No	3 L 100	ibly 4 Unkno	JWII
Vital Records,	The ate h	Completed		24a. Was an autopsy performe	d? pi	rior to comeath?	sy findings availa pletion of cause 2 No	
<u> </u>	Physician; this certifica ral director, I	Be	25. Was case referred to medical axapriner? Hospital: Hospital: Classified C					
ō	Physic this stal di	5. To	1 Inpatient 2 EH/Outpatient OA 4 Nursing Ho	me 5 🗷 Residence 28d. Desc <u>ri</u> be how				
ő	th. : After s funer	tior	27. Man er of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	self in	Firete	Do	gunsho	ST
DIVISION OF	or Attending ifter death. Director: After in by the fune	ifica	3 Suicide 6 □ Could not be determined 28e. Place of Injury 1 home, farm, street, factory, office	28f. Location (Stree	at and Numbe	r or Rural	Route Number,	-
בֿ	s after s after s Director	Certification;	4 Domicios Duilding etc. (Specify)	ed. West	State) 1231	8 W	un MD a	INT
	Hospi 4 hou Funer Felly fill	edical	29a. Certifier (Check only only only only only only only only	and due to the caus	ea(e) and man	nor ac eta	tod	LL /4
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title objectifier 22c. License number		. Date signed			
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	000	-11-	200	7	
ان	4-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N Weeks mo, 580 Northern Ave Hage 31. Date filed (Month, Day, Year) FEB 11 2009 32. Agistrar's Signatur A. Aparel	rstown	n	0 :	רטרוב	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	. 5, 5 5 5 7	- 4.6	- (r / to/	
	Registra	ar	FEB 11 2009 Duran B. Market					

DHMH 17 Rev 1/2001

Di

uane S. Hopkin	1	r. State of Maryland / Department I- For State Certificate Registrar Certificate			Mental		Reg. No.	00 05150
Physicia	ın/	Decedent's Name (First, Middle,Last)			TREE	2. Date of De Month	ath Year	Time of Death 1 0720 hrs
Medical Examir		Duane S. Hopkins, Jr. 4a. Facility Name (if not institution, give street and number)	J4b C	city Town or	Location of De	February	4c. County of De	
		4102 21 Avenue		emple Hills			Prince Geo	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 X M 2 F 16		Under 1 Year Ionths Days		/lin	8irth(MM/DD/YYYY) 9. 0/1992	Birthplace (State or Foreign Country) MD
		Usual Residence of Decedent						10d, Inside City Limits
ow any		10a. State 10b. County 10c. City, Town or Lo						1 X Yes 2 No
he Maryland or 28a-f show ified at oner.	ector	MD Prince George's Temple I		f. Zip Code			10g. Citizen of What C	Country?
the Ma	Dire	4012 - 20th Place		20748			USA	A
ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13.		cedent of His		Specify Yes or Nerto Rican, etc.)		merican Indian, Black,
r death or ite	Ĭ.	1 Yes 2 X No				ito rrican, etc.)		Black
irs afte	<u>a</u>	l or Dates:		2 X No	specify:	of work done	Specify: 16b. Kind of Busine	
72 hours n "natur al Exam	etec				DO NOT use			
yoge within ene. er tha	ompleted		ıdent				Educati	.on
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at oner	Be Co	17. Father's Name (First, Middle, Last) Duane S. Hopkins, Sr.			Tracy		, Maiden Surname)	
2121! ould be fil I Mental I: s marked ic event, i		19a. Informant's Name/Relationship (Type, Print)			t and Number	or Rural Route N	umber, City or Town, S	
and 2 shou fealth and N								s,MD 20748
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Discrematory of			netery,	Date	20c. Location - City	y or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Specify: Resurre 21. Construe of Funeral Jernical Icensee			of Facility G	/10/2009	Clinton d Funeral	
Ba perm Depa Impe							Springs,	
Physician		2 a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mo	ode of dying,	such as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)						Death
٠,		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
	iner	if any, leading to immediate cause. Enter Underlying Cause			W.			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
50, te be executed ysician and burial - transit		dd						
50, te be e nysician	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date of deli	verv
tox 6876 eath certificate eath certificate to attending phy for use as the	an/N	23b. Was decedent pregnant in the past 12 months?	Fetal de		Ectopic pre	gnancy	Month	Day Year
Box 68760, edeath certificate be the attending physical for use as the bur	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	Other	(Specify)				
ch the		Part II. Other significant conditions contributing to death but not resulting in	the under	rlying cause g	iven in Part I.			e to the cause of death?
S, P.O	ed by					-		Probably 4 Unknown
cords aw requas been 2 shoul	ompleted				<u>.</u>		s an 24b. Were prior formed? death	e autopsy findings available to completion of cause of
tal Reco cian: The law certificate has	Som	<u> </u>				1 ✔ Yes		Yes 2 No
ital sician: s certi	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	atient 3		of Death (Che	rsing Home 5	Residence 6 🗸 O	Wher: Scene
n of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	P.	1 ✓ Yes 2 No Tallipation 2 Erooutpa 27. Manner of Death 1 Natural 5 Pandias FOUND: Day, Year) FOUND: Polymer Day, Year) FOUND: Polymer Day, Year) FOUND: Polymer Day, Year)			ry at Work?	28d. Describe	e how injury occurred	and Cook
ion itendin eath. for: A	atio	1 Natural 5 Pending FOUND: Say, Teal FOUND		11	res 2 🗸 No	Subject sh	JOI	
i page ⊆ Z	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		ctory, office b	uilding, etc.	28f. Location or Town,	(Street and Number of State) State) State Hills	r Rural Route Number, City
Divis	0	29a. Certifier		at the time, da	ate and place.			
To the Hospital within 24 hours To the Funeral completely fille	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death of the best of	stigation,	in my opinion	, death occurre	ed at the time, dat	te and place, and due t	to the cause(s)
F > F 3	Me	29b. Signature and title of certifier		29c. Licens				(Month, Day, Year)
		My CUS MI		0.C.I	VI.E.		February 4, 20	009
22		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Pe	nn Street.	Baltimore,	MD 21201		
	ate	31. Date filed (Month, Day, Year) FFR 10 2009 32. Register's Signifure						
Regist		CED 1 11 YITHY / Beauty B. BOUCE				OCME		

			1 - For State Registrar	State of Marylan	-	rtificate of L		vieritai ⊓ygi R€	2009	05454	
	Physici	an	1. Decedent's Name (First, Middle, Last)	II				2. Date of Death Month 02-07-	1	3. Time of Death	
Land Market	/Medic	cal	Cecelia T. 4a. Facility Name (If not institution, give s	Harmon	4b. City, Town, or Location of Death			4c. County of Deatl	9:10 P M		
and "	Examir	ier	VILLA ROSA NURSING			Mitchell		'	Prince Ge		
E	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 04-03-1	9. Birt	nplace (State or Foreign untry)	
	Director		577-18-3196 Usual Residence of Decedent	M 2L3FF 89	Yrs.			04-03-1	919 Cli	nton, MD	
	yland	ector	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
	Ba-f s		Maryland Prince Ge	orge's	Mitche	11ville				1,□Yes 2□No	
	with the	Ģ	10e. Street and Number 3800 Lottsford Vis	ta Road		10f. Zip Code 2072	24	10	g. Citizen of What Cor USA	untry?	
	death ms 23	nera		2. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame		
21215-0036	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🕏 Widowed 4 ☐ Divorced	Armed Forces? 1		fYes, specify Cuba □Yes 2ਿ∰No	n, Mexican, Puerti	o Rican, etc.)	Specify: Wh	, etc. ite	
15-("natu	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired	ation Juring most of work	king 1	6b. Kind of Business/I	ndustry	
212	filed within Hygiene. wher than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		.erk)		US Governm	ent	
	e filed al Hyg other vent,	Be Co	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	aiden Surname)		
ylaı	should b ind Ment marked umatic e	2	William Everett T	horne	1		Nora				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example of the other traumatic event, the Medical Example of the other traumatic event, the other traumatic event, the other traumatic event of the other traumatic event		19a. Informant's Name/Relationship (Typ			g Address (Street a			City or Town, State, 2	ip Code)	
<u>o</u>			Sandra R. Thorne/n 20a. Method of Disposition			sition (Name of natory or other place			0c. Location - City or T	own, State	
Ë.			1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)			.1 Cemete		2-09	Suitland,M	aryland	
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee MO1374 MO1								
	Physician: The law requires that the death certificate be executed By William 1 and Book the attending physician and Book the attending physician and Book the attending physician and Book the attending physician and Book the phys		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deatle cause on each line.	n. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
-			Immediate Cause (Final disease or condition a								
7		Due to (or as a consequence of): b. Athero Scherotic Cardio Vas Cular Disease								11-8000	
		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause).	Due to (or as a consequence of):							
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
68760,			and a second sec	Due to (or as a consequ	uence of):						
687	tificate ng phy: as the	ledical	a.								
Вох	eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of deliv		
0.	at the dea by the a tached fo	Physician//	1 Yes 2 ANO 9 Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify)			Month	Day Year	
σ.	that the poly detact		Part II. Other significant conditions cont	ributing to death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
Records,	w requires been sign should be	ed by						1 □ Yes	2 (XNo 3 □ Pro	babiy 4 🗆 Unknown	
ecc	law re nas be 2 sho	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of	
al	ilcian: The law certificate has I ector, page 2 s							perform	ed? death? No 1 □ Yes	·_	
Vital	yslcian is certifi director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	espital:	ED/Outpotion	t 3 □ DOA Othe	-	h (Check only one,			
	ding Phy h. After this funeral c	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	28d. Describe how	ce 6 Other (Spec	ify)	
sioi	Attending r death. ector: After by the funer	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(memory bay, rear)	(Month, Day, Year) Injury Work?" M 1 ☐ Yes 2 ☐ No						
	tal or Att s after de al Direct ed in by t	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,	
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and piace pinion, death occur	and due to the car red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1100		29c. License	number 0 108		d. Date signed (Month,	Day, Year)	
)			30. Name and address of param who are	unleted cause of death (Italian	23a) /Timo F				21-110		
CK	5		30. Name and address of person who com			SALLAN	JT FOX	-N +122	2 BOWIEM	120817	
	Sta Registra		FEB 1 0 2009	32. Řeostrar's Signa	lure /						

State of Maryland / Department of Health and Mental Hygiene 009 05455 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 455 January 28, 2009 Francis John holden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emmitsburg Frederick St. Catherine's Nursing Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign
Country) 1 ⊠ M 2 □ F 89 Director Sept. 18, 1919 Washington, D.C. <u>578-09-4250</u> Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1X Yes 2 ☐ No Maryland Frederick Emmitsburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 United States 331 S. Seton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1939—

If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White \$ 3 ☐ Widowed 4 🔀 Divorced 1946 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nat any injury or other traumatic event, Ite Marier page. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supply Depot Clerk Federal Government 17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Colbert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 S. Seton Ave., Emmitsburg, MD 21727 <u>Leah Huber / Representative</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Resthaven
Memorial Gardens Feb. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland ^ 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Fundamental Service Lansee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Pont. Enter the disease, of conshock, or heart failure. List only Approximate Interval Between Opset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nmediate Cause (Final **Physician** mout disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 ian/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Physici 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ emento 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at (28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number VA Name and address of person who completed cause of death (Item 23a) (Type, Print) Emmits burg MI 5. Setor 21727 360 arrol 31. Date filed (Month, Date 32. Registra Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 05456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HELEN HEIM HAKY 30, 2009 January 11:21 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Frederick Frederick 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months Days 1 □ M 2√ F 214-10-5403 95 1913 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.

The stream of the transition of the stream of the str 1 ∏Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1305 Taney Avenue 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 No 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🛣 No Specify. Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Factory 12 should be filed who and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles E. Heim Stella Castle ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Pearre / POA 3423 B Big Woods Road, Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 2/3/09 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Pyglera, Se ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STENOSIS AORTIC **Physician** YEMRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIH Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 21 No has 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47951 02-02-2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) gly Toll House Ave. Frenenick, Mo 21701 > BTE A KAZMI, MM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

A. parke

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended #31 per FCHD KS 2/6/09 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 31, January 2009 6:00 A.M Mary Jane Houser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25900 Ridge Road Damascus Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🗙 F 74 1934 Washington, D.C. 579-44-2660 Director June Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25900 Ridge Road 20872 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: ģ 3 Xidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore George Langway Mildred Underwood 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25900 Ridge Road, Ann Houser - Daughter Damascus, Maryland 20872 Lisa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Metropolitan Crematorium 2/2/09 Alexandria, Virginia 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CARDED-PULMONARY ARREST. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MONTHS TERMENAL LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 🛣 No 5 X Residence 6 □Other (Specify) P 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred al or Attending P s after death. Certification: 1 XNatural 5 Pending investigation Injury 1 Tyes 2 No neral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours aff To the Funeral D 29a. Certifie 📆 Coctifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapping stated. 2 Medical Example one) 29c. License number 29b. Signature and title of gentify 29d. Date signed (Month, Day, Year) D50207 February 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registra s Signature Eneral

parker

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Gladys I. Henson 2009 January 1:10 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Prince Frederick Calvert County Nursing Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F 95 Yrs. Director Maryland March 14, 1913 213-44-2843 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD Prince Frederick Calvert 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20678 Funeral 2190 Adelina Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 1∑No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed by 3 N Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Irene Henson Joseph H. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troops. 2190 Adelina Road, Prince Frederick, MD 20678 Marcus Henson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Western Cemetery 2/6/2009 Prince Frederick, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Glader Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 11/0 disease or condition resulting in deeth) /Medical Due to (or as a consequence of): Examiner Demention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed chronic sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical Del IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) Ö the 9 Hunknown σ. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 1 Tyes 2 No **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗆 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident by the 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50290 1-30-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosp MD 20678 110 SUGL Thi ven 32. Registraris Signature 31. Date filed (Month, Day, Year)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 46 Harpe وناحل /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthda mor 1evsity May If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) rthday **Funeral** 1 □ M 2 □XF Hours Min Director 579-14-2594 87 19, 1921 Washington, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examination to the context once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No Maryland Anne Arundel Odenton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21113 USA 800 Yellow Birch Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2XXNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administration Assistant TRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Teano Mary Phipps ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Harper/ Daughter 6900 Oakview Court Louisville, KY 40291 20b. Place of Disposition (Name of cemetery, crematory of other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2009 Silver Spring, MD 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ha va /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trai Due to (or as a consequence of): yours after death.

eret Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a Certifier соmpletely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K (B) Rallimore modedol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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amende Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09-00926 Kerry James Jackson 2009 05460 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day February 1, 2009 Medical Examiner Kerrv James Jackson 0555 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 577**-**98**-**630**9** Days Hours Director Country) DC 1 X M 45 1963 June 12 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County District of Columbia 1 X Yes 2 No Washington 28a-f show "natural", or items 23a or 28a-f sho Examiner must be notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1505 Tubman Road, 20020 United States SE Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes Black 1 Yes 2 X No specify: 3 Widowed Specify 4 Divorced If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 15-0036 filed within 72 h d other than ", the Medical I 12 years Environmental Service Worker Private 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) timore, MD 21215.

1. Pages I and 2 should be filed thrent of Health and Mental Hyram: Hitten 27 is marked of yor other traumatic event, th James Jackson Sandra Holloway Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Gaither - Cousin 2107 Jameson Street Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: 1 Harmony Memorial Park Feb 10, 2009 Landover, MD Donation 5 Other Specify. 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral 9 4001 Benning Road, NE Washington, DC 20019 Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and lure. List only one cause on each line. /Medical Death a. gunshot wound of chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown icale has been signed by the att page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes After t 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot Natural FOUND: 1 Yes 2 ✔ No Director: d in by the f Pending Feb 1, 2009 0342 hrs 2 To the Hospital or Atte within 24 hours after dea To the Funeral Director completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1505 Tubman Road SE, Washington, DC determined 4 V Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME February 1, 2009 JR. 30. Name and address of person who convileted cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD

Registra s Signature

Sobrex Ct

frederick MD

09-01249 Glen Johnson

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	1	1- For State Registrar	Certificate o	f Death			g. No.	09 0346			
Physicia ledical Examii		Decedent's Name (First, Middle,Last) Glenn David Johnson					Day Year 1, 2009	3. Time of Death 1507 hrs			
		4a. Facility Name (if not institution, give street and number) 4515 Willard Avenue #1916		4b. City, Town, or Chevy Chas		ath	4c. County of D Montgome				
Funeral Director		138-42-9407	n yrs. last birthday) 60	If Under 1 Yea Months Day			h(MM/DD/YYYY) 9 , 1949	. Birthplace (State or Foreign Country) New Jersey			
Maryland 28a-f show any d at once.	or	Usual Residence of Decedent 10a. State									
th the Maryland 23a or 28a-f sho notified at once.	Director	4515 Willard Avenue #1916	South	10f. Zip Code	20816		10g. Citizen of What Country? U.S.A.				
ter death with	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XXDivorced If Yes, Give Year	lf `	as Decedent of His Yes, specify Cubar	n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	White, e	merican Indian, Black, tc. White			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matte event, the Medical Examiner must be notified at once	pleted by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during n	nt's Usual Occupa- nost of working life Consu	tion (Give kind e. DO NOT use		16b. Kind of Business/Industry U.S. Government				
ID 21215-0036 should be filed within 72 and Mental Hygiene. 77 is marked other than '	Be Compl	17. Father's Name (First, Middle, Last) Leonard C. Johnson				ame (First, Middle, M rgaret Ma	rst, Middle, Maiden Surname)				
mnd 2121 and 2 should be fi tealth and Mental I ten 27 is marked traumatic event,	은	19a. Informant's Name/Relationship (Type, Print) Jeffrey Johnson/son	935-	B Rolfe S	St. S.		n, Virgir	nia 22204			
MOFE Pages 1 rent of H ant: If i		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	St. Anne's	ther place) s Cemeter	ry 2	/16/2009		is, Maryland			
		21. Signature of Funeral Sen/ice Licensee 23a. Part I. Enter the disease, or complications that caused the	es 1.	47 Duke o	of Glou		., Annapo	eral Home olis, MD 21401 Approximate Interval			
Physician /Medical xaminer		$ \begin{array}{c} \text{failure. List only one cause on each line.} \\ \text{Immediate Cause (Final disease or condition resulting in death)} \end{array} \text{ a. } \begin{array}{c} Blunt force \\ Due to (or as a consequence of the condition of the cond$	e head tra		V 1			Between Onset and Death			
	miner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
executed an and al - transit	Exa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. WENDER 23a, PII, 27, 28a-f, perME, G890 4/14/89 TT									
760, Teate be execut physician and the burial - trait	/Medical	IF FEMALE: 23c. If yes, outcome					23d. Date of de	livery			
Box 687 e death certifi- the attending ed for use as t	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown g Unknown									
, P.O. Be ires that the de signed by the be detached fi	d by Phy	Atherosclerotic cardiovascular disease: chronic 1 Yes 2 No 3 Probably 4 🗸 U									
cords law requi	Completed	obstructive pulmonary disc	ease	-		24a. Was a autop perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 No			
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?			e of Death (Che						
n of Vi ding Physi a. After this funeral dir	٦.	27. Manner of Death 28a. Date of Injury	28b. Time of		ury at Work?		Residence 6 🗸 (
ion (trendin leath. A tor: A	ation	1 Natural 5 Pending (Month, Day, Year 2 X Accident Investigation	2009 Fd 14	50 hrs	Yes 2 X _{No}	subject					
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specify) 1	y - At home, farm, stre esidence	eet, factory, office t	building, etc.	28f. Location (S or Town, S # 1916 C1	Street and Number of tate) 4515 W hevy Chas	or Rural Route Number, City illard Ave e, MD			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my k one) 2 Medical Examiner: On the basis of examinand manner stated.		ation, in my opinior	n, death occurr		and place, and due	to the cause(s)			
	Σ	29b. Signature and title of certifier		29c. Licens	.M.E.		February 12,	(Month, Day, Year) 2009			
12 CAL		30. Name and address of person who completed cause of dea Russell Alexander MD. Assistant Medical		1 Penn Street	, Baltimore,	MD 21201					
St	ate	31. Date filed (Month, Day Year) 32. Registrar's	Signature	arked			DCME				
Regist	ueli	I I I I COUNT CENTUR	J. J. J. J. J. J. J. J. J. J. J. J. J. J	MACHER							

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Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	for State Registrar	State of	iviai yiai i	-	rtificate of		a Mentan	Reg. f	200	9 05463	
	1. Decedent's Name (First, Middle, Last) Jackson Stephen Jurliss 2. Date of Death Month Day February 1 2009									3. Time of Death	
an cal	Jackson Stephen					Febr	uary	1 2009 ear	06:05 A M		
ier	4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death				4c. County of Dea		
	The Annapolitan A 5. Social Security Number 6.5		Living Age (In yrs. I	lact hirthday)	Annapol	.1S If Under 24 F	rs. 8. Date o		Anne Aru		
	212-20-0854 Usual Residence of Decedent	1 DM 2 F	85	Yrs.	Months Days		in. 01/26	7192	4 Col	rthplace (State or Foreign Country) .orado	
	10a. State 10b. County									10d. Inside City Limits	
ģ	Maryland Anne Arundel West River									1 □Yes 2 ☑No	
ire									Citizen of What C	ountry?	
la I	5131 Marx Drive				20778			Un	ited Sta	ites	
nne	11. Marital Status	12. Was Decede Armed Force	es?	S. 13. V	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes o erto Rican, etc.	r No-	14. Race - Am Black, Whi		
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1X∏Yes 2 If Yes, Give Year or Date		1	I∐Yes 2∭No	Specify:			Specify:	White	
letec	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced (Give	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of v	vorking	16b.	Kind of Business	s/Industry	
dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo not use retired grapher	1)		De	fense Ma	pping Agency	
ပ္တို	17. Father's Name (First, Middle, Last					18. Mother's N	lame (First, Mic				
To Be	Stephen Jurliss					Mvra (UNKNOWN	1)			
-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street				City or Town, State, Zip Code)		
	Diane Jones/Daugh	ıter			Marx Dri		st River	, Ma	ryland 2	.0778	
	20a. Method of Disposition	Removal from St:	20b. P	lace of Dispos emetery, cren	sition (Name of natory or other plac	:e)	Date	20c.	Location - City or	r Town, State	
	4 Donation 5 Other (Specify) Kalas Crematory 02/02/2009 Edgewater, Ma									Maryland	
	21. Signature of Fundral Service Lice	22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
	Immediate Cause (Final disease or condition									Ordet and Death	
	Due to for as a consequence of): Sequentially list conditions Due to for as a consequence of): Description of the conditions of the con									De de	
ē	Sequentially list conditions,	b. — Due to (or	as a consequ	uence of):	JUNER	NIA j	PART	HIM	ull	Cherc	
mi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					•				1	
Medical Examiner	resulting in death) Lest	Due to (or	as a consequ	ience of):							
lical	•	d									
Mec	IF FEMALE:	000 16									
cian	23b. Was decedent pregnant in the past 12 months?		th 2□ Fetat nt at time of d	death 3	Ectopic pregnance Other (specify)	у			23d. Date of de Month	elivery Day Year	
ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		J J	Journal (Specify)						
y P	Part II. Other significant conditions	contributing to deat	th but not resu	Iting in the un	nderlyi ng cause give	en in Part I.	23e. [old tobacco	o use contribute t	to the cause of death?	
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								Yes	s 2 No 3 Probably 4 Unknown		
nple							– a	Vas an utopsy	prior to	utopsy findings available completion of cause of	
S							1 □ Ye	erformed?	death? 1 ☐ Ye	s 2 No	
25. Was case referred to medical examiner?								Te MAMPONTAN			
								ecity) #CF			
atio	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1										
1 Yes 2 No								and Number or Rate)	lural Route Number,		
								as stated.			
edica	(Check only 2 Medical Examone)	miner: On the bas	is of examinat	tion and/or inv	vestigation, in my o	pinion, death o	ocurred at the ti	me, date a	and place, and du	e to the cause(s)	
Z	29b. Signature and title of certifier	1/)-1			29c. License	e number	7/	290.1	Date signed (Mon	th, Day, Year)	
7	- They co	Bren	es ar	1	1)	11438		de	brushy	02,2009	
	30. Name and eddress of person who								1	, \$	
te	Michael J. LaPen 31. Date filed (Month, Day, Year)		445 istrar's Signat	Deien	se Hwy.,	Annapo	lis, MD	2140	1		
ar	FEB 03 200		~ B.	Loan	Les I						

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician homas Nathan 750 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO MEPICAL If Under 1 Year | If Under 2 TENINSUM 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days 217-22-1005 Director Maryland -15 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examinar aust be notified at Worcester 1 DYes 2 No LocomoKe Director Maryland 10e. Street and Number 10g. Citizen of What Country? 2185 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: Army 1 ☐ Yes 2 ☐ No 3 Nidowed 4 □ Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Ithu grade Track man is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Jones Corbin Albert Pages 1 and 2 should then nent of Health and Men William ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra Miriam Cane - Daughter City, md 21851 5+ Pocomoke Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important; If any In]ury or 7 14/09 4 ☐ Donation 5 ☐ Other (Specify) v.m.c Cemetery Pocomoke 22. Name and Address & Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee Hampden ave, Princess Anne, and 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Highly that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Dav Year 5 Other (specify) 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page perforn 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated within 2 29b. Signaty 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of

31494

Chris

CARROIL

m who completed cause of death (Item 23a) (Type, Print)

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egistrar's Signatu

P.O./M.E.

H50457

51.

SAUSBUM MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 05465 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MOLA Month 0337 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Henderson, NC 066-26-0759 74 8-15-1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16011 Excalibur Road 20716 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Williams Dorothy Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Khan (Son) 14604 Debenham Way Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/11/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee hopes 3401 Bladensburg Rd. Duhan Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sus Due to (or s a const uence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants: If item 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprine.

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Extractal Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit ģ icate has been si , page 2 should b Be 2

Records, P.O. Box 68760,

Division of Vital

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causs. Entar underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

the within ?

> Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 0 2009

DHMH 17 Rev 1/2001

DEFENSE

			For State Registrar	State of Mary		partment of F <i>ertificate of I</i>		lental Hygie Reg.	/11119	05466
	Physici	an	1. Decedent's Name (First, Middle, La		EN OFF			2. Date of Death	Day Year 27,2009	3. Time of Death
- 4	/Medic Examir		HILDA 4a. Facility Name (If not institution, given		TTOM	4b. City. Town. or	r Location of Death	JANUARY :	4c. County of Dea	
4	LAGIIII	CI	FREDERICK MEMORI	AL HOSPITAL		FREDER			FREDERI	
	Funeral Director		213-02-3083	Sex 7. Age (In	71 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 5, 19	9. Bir Co 737 Ten	thplace (State or Foreign ountry) nessee
	/land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	e Man	ctor	Maryland Carroll		Mount	Airy				1 □Yes 2 🔀 No
	with the	Funeral Director	10e. Street and Number 810 E. Ridgeville	Blvd.		10f. Zip Code 21771		10g.	Citizen of What Co	ountry?
	eath v	eral	11. Marital Status	12. Was Decedent Ever	in U.S. 11		ienanie Origin? (Spe		ted State	
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Madical Evariation rust be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1		3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2ऋ\No	Specify:	Rican, etc.)	Black, Whit	e, etc. hite
2-0	"natur	letec	15. Decedent's Education (Specify only highest graduation)	ducation ade completed)	(Gi	cedent's Usual Occupa	durina most of workir	ng 16b	. Kind of Business	/Industry
712	within jiene. r than	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Health Ca	•	er Fr	ederick (County Gov't
מם	be filed tal Hyg d other event,		17. Father's Name (First, Middle, Last)	1101110	iidazen da	18. Mother's Name			oddiney dov e
<u>yla</u>	should be and Menta s marked umatic ev		Bud Brewer				Daisy Gar			
Σ	nd 2 salth ar		19a. Informant's Name/Relationship (Patricia Nicholson		19b. Ma 810	iling Address (Street a	and Number or Rura ille Blvd	Route Number, Ci Mt. Air	ty or Town, State, 2 y • MD 21	Zip Code) 771
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, ci Res	position <i>(Name of</i> rematory or other place thaven al Gardens	e) Feb.	3,	. Location - City or derick, I	
Balt	permit. Page Department of Importent: If eny Injury or once.		21. Signature uneral Service Uneral	Isee		Resthaven 9501 Catoc	ruferal s	ervices,	Skkot Co	dy P.A.
			23a Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Carrie (Final disease or condition resulting in death) a. Condionumonon Arriest Due to (or as a consequence of):							
	Examiner		· /							
	70 .±	ner	Sequentially list conditions, than y, security to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a eo	neequenes of,					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· COPD						
6876 0,	tificate be executed ig physician and es the burial-transit	al E	, , , , , , , , , , , , , , , , , , ,	Due to (or as a cor		Henry Z	sisease	>		
		Medical	IE ECMAI C.		1					
C. Box	the death cert the attending ched for use e	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Cher (specify)	,		23d. Date of del Month	ivery Day Year
ν. Τ.	s that ined b	by Ph	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	requires that the een signed by th nould be detache							1 □ Yes	2 No 3 Pr	obably 4 Unknown
II Kecords,	The law ate has b	Completed						24a. Was an autopsy performed 1 Yes 2 🗷	prior to o	topsy findings available completion of cause of
VITAI	Physiclen: this certific al director,	Be	25. Was case referred to medical examiner?	Hoositeli			26. Place of Death			2010
5	Phys r this ral dir	٤,	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpati		4 Li Nuising non	ne 5 Residence		cify)
0	Attending Physiclen: er death. rector: After this certific by the funeral director,	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) Injury	Work'	rati ?° Yes 2□No	8d. Describe how in	ijury occurred	
DIVISION	spital or Atte ours after des leral Director filled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, s pecify)	treet, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
	To the Hospital or Attendi within 24 hours after death. In the Funeral Director: A mpletely filled in by the fi	Medical (29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, de mination and/or	ath occurred at the tim investigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause of at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the lift in the	ž	29b. Signature and title of certifier	00 =		29c. License		29d. l	Date signed (Month	n, Day, Year)
	12)		000.0	, M.D		MDD 6	4910		1-27-	2009
1	2/		30. Name and address of person who							
	Stat	e	Pratima Pandy, M.I 31. Date filed (Month, Day, Year) FEB 0	32. Registras	h Street	t, Frederi	ck, MD 21	701		
	Registra	ır	FEB 0	2009 Dens	un B.	parkel				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 05467 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 01 2009 Keatinge B. Keays 07:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/29/1926 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 17☑M 2□F 508-18-8010 82 Nebraska Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exeminer must be notified at once. 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7305 River Crescent Drive 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ If Yes, Give Year or Dates: 1949-63 Specify Specify 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parke Fitzgerald Keays Alice Purcell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita M. Keays/Wife 7305 River Crescent Drive, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 02/03/2009 Edgewater, Maryland 21. Signature of Fynoral Sorvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home WWW 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2. No 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 □ Accident 1 □Yes 2 ∏ No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examiner and manner stated. (Check only ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 30. Name and address of person who com eleted cause of death (Item 23a) (Type, Print) Michael J. LaPenta M.D. 445 Defense Hwy., Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 12:45 pM Rose Katz 05 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Liberty Assisted Living Potomac Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🖾 F Yrs. **Director** 93 May 06, 1915 New York 112-05-2783 Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits , or items 23a or 28a-f show traumatic event, the Medical Exactiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8919 Liberty Lane 20854 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. \$ 3 ☑ Widowed 4 ☐ Divorced "natural", Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Grants Administrator U.S. Government Pages 1 and 2 should be filed v nent of Health and Mental Hygic ant: If item 27 is marked other t Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Abraham Krakowsky Charna Lavesky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr 212 Fennel Dun Circle, Chandler, North Carolina 28715 Dr. Steven M. White, DDS - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🖾 Removal from State King David Memorial Gardens 02/06/2009 4 ☐ Domation 5 ☐ Other (Specify) Falls Church, Virginia 21. Signature of Funeral Service Li 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Hypertension resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Aortic Stenosis Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cardiac Pacemaker autopsy 2 No 1 □Yes ours after death.

eral Director: After this certification in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and Atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D35579

State Registrar

Box 68760.

P.0.

Division

DHMH 17 Rev 1/2001

8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

Susan J. Miller,

06

31. Date filed (Month, Day, Year)

February 6, 2009

			. For				artment of				giene	o o o	0 = 1 6	_
			1 - State Registrar			Ce	rtificate of	f Death				2009		9
	Physici	an	1. Decedent's Name (First, Midd	le, Last)						2. Date of De Month	Day		3. Time of Death	Л
*	/Medio	cal	Ann H. Katz 4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town,	or Location		Februa		2009 County of Dea	8:00 a [™]	_
-	LAGIIII	C	Casey House		ŕ		Rockvi				M	ontgom	ery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs	. last birthday) Yrs.	Months Days		Min.	8. Date of Bi (Month, D) 2 / 25 /	rth ay, Year)	Co	thplace (State or Foreign ountry)	n
	Director		117-20-6143 Usual Residence of Decedent		99					02/23/	1909	PO	land	
k(7	10a. State 10b. County			ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🖾 No	
-	the Ma 28a-f	recto	Maryland Mont 10e. Street and Number	gomery	51	lver S	pring 10f. Zip Code	1			10a. Citiz	en of What Co		_
	h with	al Di	PO Box 2795				20915						es of Amer	ica
	r deat	nuer	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Or ıban, Mexicai	rigin? (Spec n, Puerto R	cify Yes or No lican, etc.)	0- 1	4. Race - Ame Black, Whit		
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes. G	ive		1 ⊡Yes 2½© No	o Specify:	•			Specify: Wh	ite	
2-00	72 hou natura ical E	Be Completed by Funeral Director	15. Deceder	nt's Education est grade completed)			edent's Usual Occ		et of working	a	16b. Kir	nd of Business	Industry	
121	vithin 7	mple	Elementary/Secondary (0-12)	College (life.	DO NOT use retir	red)	X OF WORKING	9				
d 2	filed w Hygie other t	ပို	12 17. Father's Name (First, Middle,	Last)		Clerk	ξ	18. Moth	er's Name	(First, Middle			ew York	—
/lan	uld be Mental Irked o	To B	Nathan Hecker	_				Minn	ie Li	cht				
/lar	2 sho h and t is ma rauma	Ė	19a. Informant's Name/Relations Howard Katz, so			1	ng Address (Stree				-		Zip Code)	
e, l	of Health a item 27 is		20a. Method of Disposition		20b.		osition (Name of matory or other pi		Da			20915 cation - City or	Town, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maries. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sign amy injury or other traumatic event, the Middle Event, but it is be notified and once.		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	3♠ Removal from Specify)			Gardens	lace)	02/05	/2009	South	west R	anches, FL	
Balt	permit. Depart Import any in		21. Signature of Funeral Socio	Licensee		2 E 1	2. Name and Add Cdward Sa .091 ROCK	ress of Facili agel Fu CVILLE	unera PIKE	l Dire , ROCK	ction	n, Inc.	LAND 20852	
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that to only one cause on	caused the dea each line.	th. Do not en	ter the mode of d	ying, such as	s cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Seps										
T	Examiner				or as a conse	•	ection							
6	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	(or as a conse									
P	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ntia (or as a conse	quence of):								
,092	eath certificate be executed attending physician and for use as the burial-transit	calE		d										
89	ertifica ling ph e as th	Medi	IF FEMALE:	T										
Вох	attenc for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregr birth 2□Fet inant at time of	al death 3	☐ Ectopic pregna ☐ Other (specify)				2	3d. Date of de Month	livery Day Year	
P.O.	t the c by the	hysi	1 □ Yes 2X□ No 9 □ Unknown	9 □ Unk	nown					1				
Division of Vital Records, I	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant condit	ons contributing to c	leath but not re	sulting in the u	underlying cause (given in Part	l. ——				o the cause of death? robably 4 🛣 Unknow	'n
Jecc	law re has be	Completed								24a. Was	psy	prior to	utopsy findings availabl completion of cause of	le
a	Iclan: The I certificate ha ector, page									1 □Yes	ormed? 2 🖾 No	death? 1 □ Yes	s 2 □No	
Ž	Physician; r this certific ral director, a	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA C	Mhor		(Check only ne 5 ☐ Res		XOther (Soe	ecify) Hospice	-
n o	ng Ph	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date	of Injury oth, Day, Year)	28b. Time o	W	jury at ork?		8d. Describe				
isio	ttendi death. stor: A	icati	2 ☐ Accident invest	not be	e of Injury - At I	nome farm st	M 1 reet, factory, office	□Yes 2□		8f Location	(Street an	d Number or B	ural Route Number,	
Οİ	al or A s after I Directed in by	Certification: To	4 ☐ Homicide deterr	nined 200.1 lab	ling, etc. (Spec	ify)	reet, lactory, office	0		City or To	wn, State)	i Number of Ti	arai riodie Namber,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (ng Physician: To th I Examiner: On the and mai										
	vithii To th	Ň	29b. Signature and title of certific	Value	L-Pour	mi		ense number	71,2			e signed (Mon		
	12		30. Name and address of person					000	- 0		rebr	uary 4	, 2009	
			Jocelyne Toukep	Kouatcho	u, MD,	201 Ea		rsity	Parkw	vay, B	altim	ore, M	21218	
	Sta Registi		31. Date filed (Month, Day, Year FEB 05	2009 Jen	Registrar's Sign	nature fa	Kis					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1400 30,2009 January Helen Virginia Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1 □ M 2 🖾 F 10/07/1924 VA 84 Director 577-34-4428 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ito Medical Examinar must be notified at 1KLYes 2 □ No Director Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 1813 - 23rd Street, 20020 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 **X**No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 11 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Lula Hogan Roger Ferrell ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Matthews/Daughter 3901 Essex Ct., Temple Hills, MD 20748 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/2009 Brentwood, MD Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signatury of Funeral Service 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of tying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury s a consequence of): Examine requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a conse quence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No o 9 Unknown ned by the تم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sigr I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw has e 2 : autopsy performed? Je I 1 ☐Yes 2 🖾 No 1 ☐Yes 2 ☐No certificale of Vital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA After this of funeral dire Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division 1 X Natural 1 □Yes 2 □ No within 24 hours after death. To the Funeral Director: △ neral Director: / filled in by the fi 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nave and address of person who completed cause of death (Item 23a) (Type, Print) A. Cumberatch, 8416 Central Ave., Landover, MD 20785 Ophnell 31. Date filed (Month, Day, Year) State FEB 1 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 0110 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1909 Shore Drive Edgewater Anne Arundel 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Mar. 25 Hours Min. Year Davs 1 Ø M 2 □ F 73 Years 1935 West 236-54-0104 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No W. Virginia Pendleton Riverton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number H-C 78 Box 158 26814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tilson Chestly M. Lightner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) H-C 78 Box 158 Riverton, West Virginia 26814 Roselee Hinkle/Companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State North Fork Mem. Cem 4 □ Donation 5 □ Other (Specify) 2/7/2009 Riverton, West Virginia 22. Name and Address of Facility George Γ. Kalas Funeral Home 21. Signatur of Funeral Service Licenses ala 2973 Solomons Island Rd. Edgewater, Maryland from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications, or heart failure. List only one complications are complications. Immediate Cause (Final disease or condition resulting in death) on ch bys Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Exandrar roust by notified at

"natural",

d other than "nature event, the Medical

Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, the once.

Funeral Director

<u>ک</u>

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-tran certificate has been signed by the rector, page 2 should be detached this c After 1

Division of Vital Records, P.O. Box 68760,

Certification: To

Physician/Medical ģ Completed æ

within 24 hours after death

To the Funeral Director:
completely filled in by the Medical State

Registrar

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

29a Certifier

6 ☐ Could not be 3 🗌 Suicide determined 4 Homicide

> Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated. nature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who came leted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 03 32. Registrar's Signature

09-01316	
Timothy Lewis	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	(Sertificate	e of Death				Reg	. No. 21	JUS	0041
Physicia		Decedent's Name (First, Middle,L	ast)						te of Death	Day Year	3.	Time of Death
Medical Exami		Timothy Will		۳					oruary 14			0700 hrs
		4a. Facility Name (if not institution, 16301 Ayrshire Court	give street and number)		4b. City, To Hagers		cation of I	Death		4c. County of Washingto		
Funeral	30	5. Social Security Number 6.	Sex 7. Age (In y	yrs. last birthda	-		If Under		ate of Birth	(MM/DD/YYYY)	g. Birthpl oreign	ace (State or
Director	· top ty		XX _M 2 F	51	Yrs. Months	Days	Hours	Min. 07	7/08/1	957		ry) New York
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or I	Location						10	d. Inside City Limits
*	_	Maryland Wash	ington		Hagers	town					1	Yes 2 XNo
larylar at or		10e. Street and Number	gron		10f. Zip (100	. Citizen of Wha	t Country	?
h the Maryland 3a or 28a-f she		16301 Ayrshire	Court			217	40				USA	
with	era	11. Marital Status		in U.S. 13	3. Was Deceden	t of Hispar	nic Origin			14. Race - White.	Americar	n Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 XXMarri 3 Widowed 4 Divorce	1 Yes 2 1	No	1 Yes 2			derto recan	(610.)	Specify:		ite
urs af	db	15. Decedent's Education (Specify	or Dates:		cedent's Usual C				one	16b. Kind of Busi	ness/Indi	ustry
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	duri	ing most of work	ing life. Do	O NOT us	se retired)				
21215-0036 suld be filed within 72 Mental Hygiene. marked other than "	Completed	12			L	abor					Man	ufacturer
5-0 iled w Hygir d other		17. Father's Name (First, Middle, La	•			18.		,		aiden Surname)		
21215-00; uld be filed with Mental Hygiene marked other t e event, the Me	Be	Gordon Willi 19a. Informant's Name/Relationship		140%	Anilina Addanga	/Disc. 24 -24		s Mar		berty er, City or Town,	Ct-1- 7	in Code)
MD 2 nd 2 shoul alth and M m 27 is m aumatic	٩	Shannon K. Lew	(21)	9								
e, M 1 and 2 Health item 2	*	20a. Method of Disposition	2	20b. Place of D	isposition (Nam			Date	STOWN	, Mary I 20c. Location - C	and City or To	wn, State
lore ages 1 nt of H t: If i		1 Burial 2 X Cremation	Λ	-	or other place)							
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec									urg,	Maryland
Baltir permit Departm Importa		Zi. digitatel di l'allegation			425 S					/illiams	nort	, MD 2179:
Physician		23a. Fart I. Enter the disease, or co	mplications that caused the d	leath. Do not e	nter the mode of	dying, su	ich as car	rdiac or respi	ratory arres	st, shock, or hear	t	Approximate Interval
/Medical		failure. List or you one cause or Immediate Cause (Final disease	a. Hypertensive	e cardi	lovascu1	ar d	isea	se				Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a consequen	_								
	_	Sequentially list conditions,	b. Due to (or as a consequen					_			-	
	in in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.	ice or).							- 44	
ed nsit	Examiner	events resulting in death) Last	Due to (or as a consequen	nce of):								
760, foate be executed physician and the burial - transit		X UNPENDED	X AMENDED #1,23	a,PII,2	27,perME	, g88	89 3	/11/09	TT			
760, ficate be g physicia the buria	/Medical	IF FEMALE:	23c. If yes, outcome of							23d. Date of d	eliverv	
\$876 rtificate ling phy	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death	3	Ectopic p	pregnancy		Month	Day	/ Year
Box 687 e death certifit the attending	Sici	1 Yes 2 No 9 Unkno	4 Pregnant at time	of death 5	Other (Spec	ify)				1		8
D. B. trhe de by the	Physiciar	Part II. Other significant condition	9 DIKIOWII	not resulting in	the underlying	cause give	en in Part	† I	23e. Did tob	acco use contrib	ute to the	e cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ra after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	کِ	Myxoid heart			. une amaon, mg	outer give					_	oly 4 Unknown
ords, ** require s been sign should be	Completed		vaives					— L	24a. Was ar	n 24b. W	ere autor	osy findings available
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Phys Phys	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury			8c. Injury a				ow injury occurre	4	ocene .
on of Inding Ph.	Ö	1 X Natural 5 Pendin	(Month, Day,Year)		, ,		s 2 1					
ivision for Attend after death. Director:	icat	2 Accident Investig	28e Place of Injury -	At home, farm	, street, factory,	office buil	Iding, etc.	. 28f. L	ocation (St	reet and Number	or Rural	Route Number, City
Division pital or Attent ours after death teral Director.	Certification:	3 Suicide 6 Could redeterm							or Town, Sta	ate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Phys	sician: To the best of my kno									
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.			License n				29d. Date signe		
	-	1/	11.			O.C.M.				February 15		,
		30. Name and address of person w	no completed cause of death	(Item 23a)								
3H-0			Deputy Chief Medical E		111 Penn	Street, E	Baltimo	ore, MD 21	1201			
	ate	31. Date filed (Month EBY)	32. Registrar's Si	gnature _	1	,				-		
Regist	rar	LCO 7	2009	s B.	Market							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mary		ertment of He rtificate of D		lental Hyg	eg. No 20	09	05473
ī	Physicia		1. Decedent's Name (First, Middle, Last)	Miriam Lew	<i>r</i> in			2. Date of Deat Month February	th Day 04	Year 2009	3. Time of Death 8:55 p ^M
maning .	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or L	ocation of Death		4c. Count	ty of Death	
-10			12216 Somersworth I	rive			er Spring			Montg	
	Funeral Director		060-28-9380	M 2▼ F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day) May 02,		9. Birthpl Coun	lace (State or Foreign try) Poland
	land ow	ŀ	Usual Residence of Decedent 10a. State 10b. County	100	:. City, Town or Lo	cation				10	Od. Inside City Limits
	Mary a-f sh	to	Maryland Montgome	ery		S	ilver Sprin	ng			1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	f What Coun	try?
	23a	<u>a</u>	12216 Somersworth I				20902			U.S	
36	d 2 should be filled within 72 hours after death with the Maryland th and Mental Hyglene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Maricel Examination and the routiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Nas Decedent of His fYes, specify Cuban I □Yes 2 🍱 No		ecify Yes or No- Rican, etc.)		ace - Americ ack, White, e efy:	
9	2 hou	ted	15. Decedent's Educ (Specify only highest grade	ation		dent's Usual Occupa kind of work done du		na	16b. Kind of I	Business/Ind	lustry
218	within 7 jene. • than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	ang moot of works	''g		О- П-	
121	al Hygier other th		9 17. Father's Name (First, Middle, Last)			Homemaker	18. Mother's Name	(First, Middle, i	Maiden Surna	Own Ho	me
anc	ild be fi fental F rked ot tic ever	Be o		abolts				Esther Gra		,	
<u>-</u>	2 should be and Mental is marked aumatic ev	၉	Moishe Liper 19a. Informant's Name/Relationship (Tyr		19b. Mailir	ng Address (Street a				n, State, Zip	Code)
∑	and 2 s lealth ar m 27 is her trau		Deborah Lewin - Daus			Somerswort			-		
ē,			20a. Method of Disposition	2		sition (Name of natory or other place			20c. Location		
E O	Page ent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Remembrance	i	5/2009	Clark	sburg,	Maryland
Baltimore, Maryland 21215-0036	permit. Page Departmen Important: any injury once.		21. Signature of Funeral Service Incense		22 Hi	2. Name and Address nes-Rinaldi 1800 New Ham	s of Facility Funeral Ho	ome. Inc.	er Sprin	g, Mary	land 20904
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the							Approximate Interval Between
erph.	Physician		Immediate Cause (Final disease or condition	End St	ago 1	Renal	diseas-	2			Onset and Death
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O. Box	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
G .	s that ned b	by Pr	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
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of Vital Records,	siclan: The law recertificate has beerector, page 2 sho	Completed						24a. Was a autop perfor 1 □Yes	an 24t sy med? 2 X No	b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
/ita	clan: ertific	Be (25. Was case referred to medical examiner?			Otho	26. Place of Deat	h (Check only or	те)		
of \	Physic this cral dire	2	TLI fes 2 ZAINO	ospital: 1 ☐ Inpatient	2 ER/Outpatier		T I I I I I I I I I I I I I I I I I I I	me 5 A Resid			y)
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Division	Attendi death. ctor: A y the fu	ficat	3 Suicide 6 Could not be	28e. Place of Injury - building, etc. (S	At home, farm, str					mber or Rura	al Route Number,
Θį	I or Atter after dea Director d in by the	Certification:	4 ☐ Homicide determined	building, etc. (S	ipecify)			City or Tow	n, State)		
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier 1	sician: To the best of m ner: On the basis of exa and manner stated.	y knowledge, deat amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License			29d. Date sign		Day, Year)
	1		mina Fazli			D00	64871		2151	09	
	V					Print)	Rockville,	, Maryland	1 20854		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 6 2009	32. Registrar's	Signature	Kes					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:20 pm Yue Rong Liu February 03 2009 /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Casey House Rockville 9. Birthplace (State or Foreign Country) China If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs. September 22,1931 **Director** 223-61-0794 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12630 Veirs Mill Road, Apt. 713 20853 U.S.A. r death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify. ð 3 X Widowed 4 ☐ Divorced Asian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဥ ukn ukn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pei Juan Tan - Daughter 12630 Veirs Mill Road, Apt. 713, Rockville, Maryland 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/09/2009 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Crus Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Muli le Myeloma /Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit that the death certificate be executed Pneumonia Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) ed by the a Ö 9 Unknown ۵. signed t 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown as been si 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☒ No Certification: To After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ospital or Attending hours after death. 1 X Natural 5 Pending Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kou etchou, md yne 20063748 JOCEL February 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway, Baltimore, Maryland 21218 Jocelyne Kouatchou, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 5 2009 Registrar

Amend #8 Type of Prints in Black Moetible Ink. Ensure All Copies Are Legible.
amend #20b&c, Per fh 9889 3/04/09
mdn 20a, per File 889 Mary 1870 Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 200 Aemdn 20a,perFi Reg. No. 2009 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** a M 1:30 2/6/2009 GLORIA GARDNER MATHIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5/25 | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) Buena Vista, GA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕏 F 5/22/1940 Director 68 422-58-5315 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov 1X Yes 2 No Director Camp Springs Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 United States 6108 Rayburn Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic event College (1-4or 5+) Elementary/Secondary (0-12) Georgia Public Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Sam Gardner Tommie Elsie Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6108 Rayburn Drive Camp Springs, Maryland 20748 Milton H. Mathis / Husband 20b. Place of Disposition (Name of Arthurston Narches place) 20c. Location - City or Town, State Arlington, VA 20a. Method of Disposition 2/23/2009 1 ☐ Burial 2 Ed Gremati n 3 ☐ Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 21. Signature of Furreral Service Licen 22. Name and Address of Facilit Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Inter the disease, or implications that caused the shock, or heart failure. List only one cause on such line Senticemis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical as IF FEMALE: for use If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Megical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and tip 29d. Date signed (Month, Day, Year) D0055120 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rich Alo Palmer MD 1328 Southern avenue Suite 310 Washington De 20032 38 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 0 2009 Registrar

Baltimore, Maryland 21215-0036 other

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year P^{M} McPherson, Jr. Α. January 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4015 Lomar Drive Frederick Mt. Airy If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington **Funeral** 1**⅓**M 2□F Yrs. Director 224-40-5996 72 16, 1937 Jan. Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4015 Lomar Drive 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil tment of Health and Menfal H fent: if Itam 27 ie markad ott lury or other treumatic even Robert A. McPherson, Sr Marian Liles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Lee McPherson/Daughter 4015 Lomar Drive Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 3, 2009 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY
Due to (oras a consequence of): **Physician** week /Medical Examiner Sequentiary list do actions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year Due to (or as a cor sequence of) Examine physicien and the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical affending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 res 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No မှ Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sarrele CENP R086637 February 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen R. Farrell, C.R.N.P. 602 Center Street Mt. Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Registrar Signature

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21215-0036

	1 - State Registrar				C	ertificate of	f Death	Re	g. No. 20	19 051
ın	1. Decedent's Name			nos agas agas				2. Date of Death Month		3. Time of I
			N MCCARDE			T		JANUARY		
	4a. Facility Name (I		, give street and no RIAL HOSF	,		4b. City, Town, FREDER	or Location of Dea こてこと	h	4c. County of FREDER	
	5. Social Security N		6. Sex	7. Age (In yrs.	last birthda	(v) If Under 1 Year	r If Under 24 Hrs	8. Date of Birth	1 9	. Birthplace (State or
	216-14-5		1 3 M 2□ F	95	Yrs.	Months Days	s Hours Min	June 8,	Year)	Country) Marvland
Ì	Usual Residence of	_		T						
_	10a. State	10b. County Freder	ri oli		ty, Town or! derick					10d. Inside City
DIFECTOR	Maryland		. ICK	116	delici			140	000	
	10e. Street and Nur					10f. Zip Code		10	g. Citizen of Wha	at Country?
Laileiai	301 Rock	Mell le		cedent Ever in U	.S. 13		701 Hispanic Origin? (Specify Yes or No-	USA 14. Race -	American Indian,
5	1 X Never Marri	ied 2 Marri	Armed F ied 1 ⊠Yes	2 🔲 No		_	Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)		White, etc.
2	3 Widowed	4 Divorced	If Ŷē s, G Year or I	live Mala	II	1 ∐ Yes 2 🔀 No	o Specify:		Specify:	White
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מ	17. Father's Name (me (First, Middle, M	,	
2	Adrian 19a. Informant's Na				405 14-	tion Address (Otto			ingan	7. 0.11
	Ed Garret							ural Route Number, ive, Fred		
ŀ	20a. Method of Disp		ПОР	20b.		position (Name of ematory or other pla				ty or Town, State
		☐ Cremation	3 Removal from	1 State		ematory`or other pla Jet Cem	(ace) { 2/5/		rederic	
}	21. Signature of Fu			TIC		22. Name and Add		tauffer F		•
	Por	- um	relui	>				ike, Fred		
1	23a. Part I. Enter th	he disease, or	complications that	caused the dea				c or respiratory arres		Approximate
	Immediate Cause (only one cause on	each line.			,			
			12	Jacke	CC	a cialm	_	con CON		Interval Betw Onset and Do
	disease or condition resulting in death)					acioum	_	ion cell		
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Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

	1 - State Of IVI		epartment of F Certificate of L			. No.	054/8
an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
cal	GARY LEE MOORE				JANUARY :	28,2009	9.53A M
ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
	FREDERICK MEMORIAL HOSPI 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthd	FREDERIC	K. If Under 24 Hrs.	8. Date of Birth	FREDERI	
	563-40-7233 1⊠M 2□F Usual Residence of Decedent	72 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 14	1936 Ca	rthplace (State or Foreign Country) 1ifornia
_	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
ecto	Maryland Frederick	F	rederick				1 ☐ Yes 2 ☒ No
ä	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	ountry?
eral	8623 Pinecliff Drive	5in 11 0	2170		16-24	United S	
E.	11. Marital Status	Everiii G.S.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
by	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify: W	hite
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occupa	ation Juring most of worki	ing 16	b. Kind of Business	s/Industry
ng(Elementary/Secondary (0-12) College (1-4or 5	- life	e. DO NOT use retired)	'i'g		
	4	Na	aval Aviato			U.S. Nav	у
Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	iden Surname)	
မ	Lorin A. Moore	105.14	-: No. o. Antologo (Character	Rachael			
	19a. Informant's Name/Relationship (Type. Print) Margaret B. Moore / Wife	1	ailing Address (Street a				
	Margaret B. Moore / Wife 20a. Method of Disposition		3 Pinecliff sposition (Name of crematory or other place		Frederick	c. Location - City or	
	1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place r Crematory	Jan	uary	ĺ	Maryland
	21. Signature of Funeral Service Licensee		22. Name and Addres	. 515	auffer Fu	neral Hom	
	23a. Part 1. Enter the disease, or complications that caused	the death. Do not		_			Approximate Interval Between
	shock, or heart failure. List only one cause or each lind immediate Cause (Final disease or condition	Strand	Aortie	Anexa	(SI n		Onset and Death
	resulting in death)		1-101 110	7 10 1 - 11	29.7		1 har
	Sequentially list conditions, b.	se A A	tortic 1.	Assect	tan		1 Month
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Be Completed by Physician/M	In the past 12 months:	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of de	elivery Day Year
hysid	1 Yes 2 No 4 Pregnant a 9 Unknown	time of death	3 Li Other (specify)				
by P	Part II. Other significant conditions contributing to death b				23e. Did tobac	co use contribute t	o the cause of death?
ed	Atrica tibrillation on		JUSY WYLOW	`	1 ☐ Yes	2 □ No 3 □ P	Probably 45 Unknown
nple	S/P engovasevian stent	12/27/0	78		24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ខ	<u> </u>				performed 1 □ Yes 2 5		s 2□No
Be	25. Was case referred to medical examiner? Hospital:		tiont 3 DOA Othe	26. Place of Death			
<u>ا:</u>	1 ☐ Yes 2 ☐ 1 ☐ Inpatie 27. Manner of Death 28a. Date of Inju		tient 3 DOA	4 LJ Nursing Hol	me 5 Residence 28d. Describe how		ecify)
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fica	3 Suicide 6 Could not be	ury - At home, farm,	street, factory, office		28f. Location (Stree	et and Number or R	ural Route Number,
Serti	4 ☐ Homicide determined building, etc.	c. (Specify)			City or Town, S	State)	
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/o	eath occurred at the tin r investigation, in my op	ne, date and place, pinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
Me	29b. Signature and title of certifier		29c. License	number	29d	Date signed (Mon	th, Day, Year)
741	manchy (ham)		04	6248		1)29/0	9
	30. Name and address of person who completed cause of d		pe, Print)	94 52	wat Fre	Sand M.	02127
te	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	77				
ar		and the	2 1. 70 K.				

			For State Registrar		partment of Health and ertificate of Death	Mental Hygien Reg. N	2000	05479
	Physicia	an	1. Decedent's Name (First, Middle, La			2. Date of Death Month D	ay Year	3. Time of Death
14	/Medio	al	4a. Facility Name (If not institution, giv	Milbourne Sr	4b. City, Town, or Location of Deat	1	7 2009 c. County of Deat	
أمر			Manokin A 5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthda	Princess And If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Year	Somer 9. Birt	thplace (State or Foreign
	Funeral Director		219-14-1697	ØM 2□F 92 Yrs.	Months Days Hours Min.	Jan 17 1	(217 NA	ciry and
	ryland thow	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or				10d. Inside City Limits
	the Ma 28a-f s	recto	Mayland Baltmu 10e. Street and Number	re City Balti	MU'C- 10f. Zip Code	10g. C	Citizen of What Co	1 Yes 2 No ountry?
	ath with	Funeral Director	1100 Pennsylva		21201	Uni		
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mydical Examinat, ust be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 Mes 2 No Avrmy If Yes, Give Year or Dates: 1941-1944	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puer □ Yes 2 No Specify:		14. Race - Ame Black, White Specify:	e, etc.
215-(hin 72 h e. an "natu Madical	Completed by	15. Decedent's Ed (Specify only highest gra	ade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of wo. b. DO NOT use retired)	rking 16b.	Kind of Business/	Industry
d 2121	filed with Hygiene other tha		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last		Laborer 18. Mother's Na	me (First, Middle, Maide	Retai	
Maryland	should be fund Mental marked o	To Be	Marion L	Milbourne_	Ann	1331	Mes	
	and 2 sho ealth and n 27 Is mi		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or R ついといく コラミ M	ural Route Number, City	or Town, State, 2	Zip Code) S.38
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	comatant of	position (Name of rematory or other place)		Location - City or	Town, State
altim	t. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		zer Cowetten Tek 22. Name and Address of Facility	14, 2004 1 nthonus E.	Marian L Word F	Waryland uneral Hamo
8	permi Depa Impo any ir		23a, P. t. Enter the disease, or com	plications that caused the death. Do not e	30639 Hampde	nave Pri		ne, MD 2185 Approximate
	Physician		short, or heart failure. List only Immediate Cause (Final disease or condition			or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):				
Ć.	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequence of):				
68760,	icate be physicia the bu	edical		■ d.				
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
σ.	ires that the de signed by the a d be detached to	by Ph		contributing to death but not resulting in the	e underlying cause given in Part I.			the cause of death?
of Vital Records,	w require been si should t					1 ☐ Yes 24a. Was an	T	robably 4 Unknown
l Re	The law ate has page 2 s	Completed				autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 □No
Vita	Physician: The this certificate head director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	lau A	ath (Check only one)	0.500	~ .
n of	ਲ ਦੇ ਨ	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	e of 28c. Injury at Work?	Home 5 ☐ Residence 28d. Describe how inj		всіту)
Division	I or Attending after death. Director: After I in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street a	a <i>nd Number</i> o <i>r R</i>	ural Route Number,
Ö	보는 다		4 Hornicide	building, etc. (Specify)		City or Town, Sta		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occ	urred at the time, date a	and place, and due	e to the cause(s)
	withi To th	Ž	29b. Signature and title of certifier	completed cause of death (Item 23a) (Typ 47 2009 32. Rigistrar's Signature	29c. License number	29d. E	Date signed <i>(Mont</i>	th, Day, Year)
4+	1 eb		30. Name and address of person who	completed cause of death (Item 23a) (Typ	v,5:00 Sheer	SALLSBURY	MD 3	2,804
	Sta Registi	ate rar	31. Date filed (Montifica BYayr)	2009 32. Rigistrar's Signature	pares			
			999-		-			

			State of Maryla 1- State Amend Items 23aPtII,25,	nd / Depa 27 , 282 – <i>Cer</i>	rtment of Heal f per me g8 tificate of Dea	th and M 92,06/1	ental Hyg and B	iene eg. No.200	9 05480
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physicia /Medic		Marcus Llewellyn Neal, Sr.				_	02, 2009	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca Annapoli			4c. County of D	
<u> </u>	Francis		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Funeral Director		217–72–5321 ^¹ X м ²□ ғ 49	Yrs.	Months Days Ho	ours Min.	June 17	, 1959 Ma	aryland
	pug w		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	tor		Annapol					1 X Yes 2 No
	r 28a-	irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
	th with 23a o	ralD	8 Melrob Court Apt # 4		21403			USA	
	tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13. V	Was Decedent of Hispani f Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
20	rs afte	by F	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced 7 ear or Dates:		1 □Yes 2 🎇 No <i>Spe</i>	ecify:		Specify:	Black
5	2 hou latura ical E		15. Decedent's Education	16a. Deced	dent's Usual Occupation kind of work done during	a most of worki	20	16b. Kind of Busine	ess/Industry
7	thin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. [DO NOT use retired)	THOSE OF WORKI	ig		
7	led wi Hygier her th		10 17. Father's Name (First, Middle, Last)		Chef	Mother's Name	/First Middle II	Restau Maiden Surname)	rant
<u></u>	d be fi ental F ced of c evel	o Be	Herman Augustus Neal					Sharps	
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantual recount be notified at	오	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and N		•		te, Zip Code)
, M	and 2 salth a 127 is er tra		Valerie Diane Neal/ Wife	8 Mel	rob Court,	Apt. 4	, Annapo	olis, MD 2	21403
บ ว	jes 1 st of He If item		20a. Method of Disposition 20b. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Re	Place of Dispos	sition (Name of natory or other place) Memorial	Feb.	0.0	20c. Location - City	
altillo	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)	F	Park	- 20	009	Annapolis	
0	permit. Pages 1 and 2 shand 2 shand 2 shand 1 mportant: If item 27 is many injury or other traum once.		21. Signature of Funeral Service Licensee	Bá 49	irranco & Scool Ritc	ons, P.Z chie Hw	A. Sever	rna Park I rna Park.	Funeral Home MD 21146
			23a. Fart 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Live	vcivrhosis				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conse	quence of):		0	000		'
ŧ.		Jer.	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying	equence of):			OV	WASHINER.	
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.		OFFITIEIC	ATION APPROV	ED BY MEDICAL E	XAMINA	
,007	oe exe cian a nurial-t	EX	resulting in death) Last Due to (or as a conse	quence of):	CERTITIO				
0		dical	d						
YOU	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of	delivery
0	death le atte	Physician/M	in the past 12 months? 1 ☐ Live birth 2 ☐ Fe' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐Ectopic pregnancy ☐Other <i>(specify)</i>			Month	Day Year
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'n	ires th signed	þ	Part II. Other significant conditions contributing to death but not re			Part I.		2	e to the cause of death?] Probably 4 [] Unknown
ecords,	v requ	etec					24a. Was a		autopsy findings available
Į,	he lav e has	Completed					autops	sy prior med? deat	to completion of cause of h?
א וומוי	an: T	a l	25. Was case referred to medical		26.	Place of Death	1 ☐ Yes :	*	Yes 2□No
>	hysici nis ce direc	To B	examiner? 1 X Yes Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Other: 4	☐ Nursing Ho	me 5 Reside	ence 6 Other (5	Specify)
5	ing Pl		27. Manner of Death TENatural 2 △ Accident 5 ☐ Pending investigation investigation 5 ☐ Pending (Month, Day, Year) 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury Found:	28c. Injury at Work?	1		ow injury occurred	onmental cold.
ISION	death ctor: /	icati		Unknow	m	2.110			
2	al or A after i Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec Sidewalk	cify)	oot, lactory, office FOG		City or Town	ive, Annap	r Rural Route Number, d: 111 Hills- olis.MD
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my kr 2 Medical Examiner: On the basis of examination and manner stated	nowledge, death nation and/or in	h occurred at the time, da vestigation, in my opinior	ate and place,	and due to the c	ause(s) and manne	er as stated.
	ro the	Med	and marrier states.		29c. License num	nber	2	9d. Date signed (M	lonth, Day, Year)
			Jren (beh, rus)		Dul	6052		21210	9
	3,00	M	30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print) Liway anna	polos, 1	w		
	Sta Registr	ite rar	30. Name and address of person who completed cause of death (lite \$\)\[\]\[\]\[\]\[\]\[\]\[\]\[\]\[nature.	arkel				

			For State	State	of Maryla	•		Health and M	, ,		0.0	05101
			Registrar			Cei	rtificate of	Death		g. No. 20	09	05481
	Physicia	an	Decedent's Name (First, Middle	e, Last)					Date of Death Month	Day	Year	3. Time of Death
	/Medic			Tien Hai N	<u> </u>				February	04	2009	1:40 p ^M
	Examin	er	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of Death		4c. County	of Death	
ar C			12618 Bear Cree		T= :			Beltsville	1.5.5	Pr		eorge's
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F		vrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		Coun	* *
Ac.	Director		586-42-0647 Usual Residence of Decedent			56			October 10) , 1952	V	ietnam
	and and		10a. State 10b. County		10c.	City, Town or Lo	cation				10	Od. Inside City Limits
	Mary f sh	Ö	Maryland Prince	ce George's				Beltsville				1 □Yes 2 No
	the 28a	Director	10e. Street and Number	ce George s			10f. Zip Code	Dertsville		g. Citizen of V	Vhat Count	trv?
	with		12618 Bear Cree	k Torraco				20705			U.S.	A
	ns 2	Funeral	11. Marital Status		edent Ever in	n U.S. 13. 1	Was Decedent of H		pecify Yes or No-	14. Rac	e - Americ	
0	fter o	Ā	1 ☐ Never Married 2 🖪 Marr	Armed F	orces? 2 🔀 No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White, e	
- - - -	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 □Yes 2 🗷 No	Specify:		Specify	<i>'</i> :	Asian
2	2 hol	ted	15. Decedent	t's Education		16a. Deced	dent's Usual Occup	pation	. 10	6b. Kind of Bu		
ν Ο	hin 7	ple	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life. I	OO NOT use retired	during most of work d)	aing			
N	d wit	Completed	, , , , , , , , , , , , , , , , , , , ,		+	E1e	ctrical Eng	gineer		U.S. G	overnm	ent
and	al Hy loth	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Surnam	re)	
<u>a</u>	uld b Ment Ment rrked stic e	70	Trieu Hai	Ngo				N	huong Thi T	ran		
0	and is me		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	g Address (Street	and Number or Rui	ral Route Number,	City or Town,	State, Zip	Code)
Σ.	and and a salth n 27		Dieu-Anh Hoang	- Spouse		12618	Bear Creel	k Terrace,	Beltsville,	Maryla	nd 207	05
ore	of H		20a. Method of Disposition 1 x Burial 2 □ Cremation	2 Demoval from		 b. Place of Dispo cemetery, cren 	sition (Name of natory or other plac		Date 20	Oc. Location -	City or To	wn, State
altimol	Pag ment ant: I		4 □ Donation 5 □ Other (S			Gate of He	aven Cemeto	ery 02/1	4/2009 S	ilver S	pring,	Maryland
ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mential Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Evening must be rectified at once.		21. Signature of Funeral Service	Livensee		22 H	. Name and Addre	ss of Facility di Funeral	Home Tric			
D.	70 E # 9		Tomas	ren	lan.	i	1800 New Ha	ampshire Ave	enue, Silve	r Sprin	g, Mar	yland 20904
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de	eath. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,		Approximate Interval Between
F	hysician		immediate Cause (Final disease or condition	М.	0 100	tote	CNOW	malloell	lund o	neces	- 2	Onset and Death
,	/Medical		resulting in death)	Due to	(or as a cons	sequence of):		· satisfies t		dent Land		Q red res
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	si ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a cons	requence of).						
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֝֝֟֝֝֟֝֝ ֡	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 F	etal death 3	Ectopic pregnanc	ey .			e of delive	ry Day Year
j į	the di	ysic	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unk		ordeath 5L	Other (specify) _					
r.	mar mar mar mar mar mar mar mar mar mar	Phys	Part II. Other significant condition	ons contributing to d	leath but not i	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	.cco use conti	ribute to the	e cause of death?
cords,	w requires that the or been signed by the should be detached	d by					, ,		1 ☐ Yes	2 No	3 ☐ Proba	ably 4 ☐ Unknown
Ş	been peen shoul	Completed										•
<u>.</u>	has ye 2 s	шþ							24a. Was an autopsy performe	l r	Were autop prior to con leath?	osy findings available npletion of cause of
5	r: Ir ficate f, pag										Yes	2 5 400
\	certif	Be	25. Was case referred to medical examiner?	Hospital:			A A D DOA Oth	or:	h (Check only one)			
5 8	this aldii	은	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien	1 3 DOA	4 □ Nursing Ho	ome 5 Residen)
= :	After fune	io	1 ☑ Natural 5 ☐ Pending	(Moi	nth, Day, Year		28c. Injur Work M 1 🗆	yai k? Yes 2 □ No	28d. Describe how	injury occurr	ea	
I SIOISIA	death death ctor: y the	ical	3 ☐ Suicide 6 ☐ Could r	ot bo	e of Injury - A	t home farm stre			28f, Location (Stre	at and Numb	or or Dural	Pouto Number
<u> </u>	after Direction of the property of the propert	Certification:	4 ☐ Homicide determ	ned build	ling, etc. (Spe	ecify)	eet, factory, office		City or Town,		er or nurar	House Walliber,
-	spira iours neral		29a. Certifier 1 ☐ Certifyin	g Physician: To th	e best of my I	knowledge, death	occurred at the tir	me, date and place,	and due to the cau	use(s) and ma	anner as st	ated.
	or in rospital or Attending Prystoan: The law requires that the death certificate to the rospital or the rest death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical one)	Examiner: On the	basis of exam nner stated.	nination and/or in	vestigation, in my o	ppinion, death occur	red at the time, dat	e and place, a	and due to	the cause(s)
i	To the comp	ž	29b. Signature and title of certifier	20 1	2 -	M.	29c. Licens	e number	290	I. Date signed	(Month, E	Jay, Year)
1	(Mulie	Trak	ner		DOC	051770	FE	brua	145	72009
	_		30. Name and address of person	who completed cau	se of death (I	tem 23a) (Type, I	Print)	1			7	
			Julie & Bra	honor t	1D, 16	5001	leanss	e number 051770 Hreet Ba	1timore	Man	lanc	121231
	Sta		31. Date filed (Month, Day, Year)	200	Registrar's Sig	gnature				/		
	Registra	ar	FEB 06 2	009 Jen	we p	a. Apau						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01259 State of Maryland / Department of Health and Mental Hygiene Mason Nance 2009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 11, 2009 1922 hrs Medical Examiner MASON NOAH CARTER NANCE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral** Months Min Director Country) 170-80-0600 04/01/2001 MD 1 X M 2 F 7 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No PA Delta s 23a or 28a-f show e notified at once. York with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number USA 17314 97 Watson Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married White Yes **X** Divorced If Yes, Give Year Yes 2 X No specify: the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ Student Elementary School is marked other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Beth Foard Jason Howard Nance Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 should nent of Health and Mea 19a. Informant's Name/Relationship (Type, Print) 97 Watson Road, Delta, PA 17314 Jason H. Nance/Father If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 2/16/2009 Leola, PA Evans Eagle Crematory Donation 5 Other/Specify. b 22. Name and Address of Facility 21. Signature of Funeral Se Vic Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval 23a. Part I. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death **Pyelonephritis** Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed 23a,27,permE, g893 7/15/09 TT nysician/Medical X UNPENDED AMENDED ed by the attending physician a detached for use as the burial -23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions è Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 8th performed? death? ✓ Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other₄ examiner? Nursing Home 5 Residence 6 2 V ER/Outpatient 3 Inpatient 1 ✓ Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) Manner of Death Division ▼ Natural Yes 2 No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Certif or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 12, 2009

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

TED O Q SAAC

				Department of Health and Me Certificate of Death		
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	OWENS 2	Date of Death Month Da	av. Year /9 N M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 16020 Alderwood Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	4b. City, Town, or Location of Death Bowie hday) If Under 1 Year If Under 24 Hrs. 8		c. County of Death rince George's 9. Birthplace (State or Foreign
	Funeral Director		217-44-8514 1 M 2 F 64 Usual Residence of Decedent	Yrs. Months Days Hours Min.	Month, Day, Year	() Country)
	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Examinating the notified at	Director	10a. State 10b. County 10c. City, Town Maryland Prince George's Bowie 10e. Street and Number	or Location	10g, C	10d. Inside City Limits 1. Wayes 2 □ No itizen of What Country?
	er death with tems 23a o	Funeral D	16020 Alderwood Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	20716 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric	ty Yes or No- can, etc.)	A 14. Race - American Indian, Black, White, etc.
-0036	2 hours afte atural", or i	þ	1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 15. Decedent's Education 16a.	1 ☐ Yes 2X No Specify:	16b. H	Specify: White Kind of Business/Industry
Maryland 21215-0036	led within 7, tygiene. her than "n nt, tre Medi	Completed		(Give kind of work done during most of working life. DO NOT use retired) me Maker	Own	n Home
ıryland	should be fil nd Mental H marked otl matic ever	To Be	James Albert Mangum 19a. Informant's Name/Relationship (Type, Print) 19b.	18. Mother's Name (F Gladys Lee Mailing Address (Street and Number or Rural F	e Grey	
re, Ma	s 1 and 2 s f Health ar item 27 is other trau		Hugh D. Owens/ Husband 1	6020 Alderwood Lane Bo Disposition (Name of y, crematory or other place)	owie, MD 2	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.			incoln Cemetery 1/30/2 22. Name and Address of Facility Rober		entwood, MD ns Funeral Home
m M	e a I be		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	16000 Annapolis Road	Bowie, N	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	20/CE		Onset and Death
H		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	" HAPENTENS		year
8/60,	cate be executed physician and the burial-transit	dical Exa	that initiated events ' c Due to (or as a consequence o	f):		
O. Box 68	attending for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P	equires inativen signed bould be deta	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?
vital Records	in: The law re ificate has be or, page 2 shu	Completed	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
OT VI	er this cert eral direct	n: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of Injury 28b. Ti	ime of 28c. Injury at 28d		6 ☐ Other (Specify)
DIVISION	The reported of the fundamental properties of the completely filled in by the fundamental precipits. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To	1	M 1 □Yes 2 □No		nd Number or Rural Route Number,
the Moenie	the Funera	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and lor investigation, in my opinion, death occurred	d due to the cause(s at the time, date an	i) and manner as stated. d place, and due to the cause(s)
١		Σ	29b. Signature and title of certifier	29c. License number 7 1438	29d Da	nte signed (Month, Day, Year) Way 27, 209
	BH	10	30. Name and address of person who completed cause of death (Item 23a) (1) A W W W W W W W W W W W W W W W W W W	Type, Print) YHT DEFONSE A	GHWAY 1	ANNAPOLO MOZIKO
	Sta Registra		FEB 03 2009 Janua A.	barrel		

	1 - State Registrar					rtificate d			/lental Hy	Reg. No	200) 9	0548
ian	1. Decedent's Name		,						2. Date of De	ath			3. Time of Death
cal	Mary Elle								Month 1/2	29/20	09	/ear	432A
er	4a. Facility Name (If			r)		4b. City, Tow	n, or Locat	tion of Death		4c.	County of	Death	
	2801 Libe 5. Social Security Nu			Age (In yrs. la	ast hirthday)	Bo If Under 1 Ye	owie	nder 24 Hrs.	8. Date of Bir	th	Princ	ce Ge	eorge
	122-28-64	1[72	Yrs.	Months Da			8. Date of Bir (Month, Da 1/4/1	un ay, Year) Q Q 7	"	Count	ace (State or Forei ry) IY
	Usual Residence of D	Decedent							1/4/1	931		I	N I
_	10a. State	10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limit
Funeral Director	MD	Prince (George		Bowie								1 □ Yes XXN
בֿ	10e. Street and Number 2801 Libe:					10f. Zip Coo				10g. Cit	tizen of Wha		ry?
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ğ	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates	:	1	∐Yes 21€	No Spe	cify:			Specify:	Wł	nite
etec	(Specifi	15. Decedent's Edu y only highest grad	cation le completed)		16a. Deced	lent's Usual Oc	cupation	most of work	ina	16b. Ki	ind of Busir	ness/Indu	ustry
Completed by	Elementary/Second		College (1-4or	5+)	_	kind of work do OO NOT use re			9				
	12 17. Father's Name (F	First, Middle, Last)				Manager		other's Name	e (First, Middle,		edit	Unic	on
lo Be	Eugene Mcl								et Ryan		Surname)		
É	19a. Informant's Nan		rpe. Print)		19b. Mailin	g Address (Str			al Route Numb		or Town St	ate Zin i	Code)
	Thomas F.	O'Connor	Spous	۵					wie, MD			uto, 210 t	5000)
	20a. Method of Dispo	sition		20b. Pla	ace of Dispos	sition (Name of natory or other	F_A(r nlace)	00	Date MD		cation - Cit	ty or Tow	n, State
	1y⊟xBurial 2 ⊔ 4 □ Donation 5	Cremation 3 ☐ F ☐ Other (Specify)	Removal from State			tion Ce		y 2/2	/2009	C1i	nton,	MD	
	21. Signature of Fund	eral Service Licens	ee	- i c					desty F				Р.А.
	17mg	1.	-		12	Ridgel	y Ave	. Anı	napolis	, MD	2140	1	
		lallule. List only of	ications that cause ne cause on each l	ed the death. line.	Do not ente	er the mode of	dying, suct	n as cardiac	or respiratory a	rrest,			Approximate nterval Between
	Immediate Cause (Fi disease or condition resulting in death)	inala	a	Jer	ral	Jane	100					- '	Onset and Death
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Φ	Sequentially list cond	litions,				cirrho	sis						
E III	Sequentially list cond cause. Enter Underly Cause Disease or in	litions, eclass ving jury		a noneaque		cirrho	sis						
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Medical Certification: To Be Completed by Physician/Medical Examiner	cause. Enter Under Cause (Disease or In that initiated events resulting in death) La: IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 yellow (Disease or International Part II. Other signification of Death 1 Natural 2 Acident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title	oregnant orths? No ant conditions cordinated to medical investigation 6 Could not be determined Sertifying Phys Medical Examir	Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Pregnant and Unknown Ospital: 1 Inpati Z8a. Date of Injute (Month, Data) Z8a. Place of Injute (Month, Data) Z8a. Place of Injute (Month, Data) Description: To the best of and manner st	e of pregnan 2 Fetal cat time of deat time of death ent 2 E Eury ay, Year) 2 2 2 2 2 2 2 2 2 2 2 2 2	cy Jeath 3 ath 5 sing in the und R/Outpatient Bb. Time of Injury le, farm, stree	Ectopic pregnother (specify) derlying cause 3 □ DOA □ 28c. Ir M □ 1 at, factory, office coccurred at the sestigation, in meaning the section of the sec	26. Pl 26. Pl Ther: 4 Tork? Yes 2 e time, data y opinion,	ace of Death Nursing Hor	24a. Was a autop perfor 1 Yes (Check only or Resid 28d. Describe h City or Toward due to the ced at the time, or	obacco use system of the syste	Month se contribu No 3[24b. Wer prio deat 1 [7 occurred d Number of and manne place, and e signed (M	re autops r to compute to compute to the computer to compute (Specify) or Rural F er as stard due to the control of the cont	cause of death? cause of death? Unknown of findings available oletion of cause of No Route Number, ted. ne cause(s)

			For State RegistrarMFND#17,18		Maryland / D	epartment o			giene Reg. No. 2009	05485
	sicia edica	n	Decedent's Name (First, Middle		ie F. ORII	NG .		2. Date of Dea Month Februar	Day Year	3. Time of Death 10:00 A
	ımine		4a. Facility Name (If not institution			,	n, or Location of Dea	th	4c. County of Dea	
Fund	eral		Shady Grove Adv 5. Social Security Number	6. Sex 7.	PTT& I Age (In yrs. last birth	day) If Under 1 Ye			Montgo	mery rthplace (State or Foreign ountry)
Direc		_	044-14-4263	1 □ M 2 X □ F	85 ^Y	s. Months Da	ys Hours Mir	Aug. 19		necticut
rland	1	- 1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
e Mary la-f sh	Dall linea	cto	Maryland Montg	omery	Rocl	cville				1 ☐ Yes 2 ☐XNo
th with the	DI DE LE	<u> </u>	10e. Street and Number 14411 Traville	Gardens Ci	rcle #3091	3 10f. Zip Coo	20850		10g. Citizen of What C United St	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	EXSPIRITE IN	by Fu	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 \(\subseteq Yes \) 2 If Yes, Give Year or Date	es? XNo	13. Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☐	of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene.	e medical	Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4c		ecedent's Usual Oc Give kind of work do ife. DO NOT use re Homemake	one during most of wo tired)	orking	16b. Kind of Business Own Home	,
/land 2 uld be filed Wental Hygi	Itic event, I	To Be Co	17. Father's Name (First, Middle, L	ast) Jacob F Joseph F			18. Mother's Na Berti —Bert	ne (First Middle, na Cohen na	Maiden Surname)	
Mary d 2 sho th and 1	traums		19a. Informant's Name/Relationsh						er, City or Town, State,	Zip Code) 20850
s 1 and of Heal	ome	1	20a. Method of Disposition	· ·	20b. Place of D	risposition (Name of crematory or other		Date	20c. Location - City of	
Page Page ment c	ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tte i		:	02/06/0	9 Falls C	hurch, VA
Balt Depart Import	once.		21. Signature of Fune (1. servise)		5	22. Name and Ad Torchins	Ly Hobrow	Funeral	Home	
		+	23a. Part 1. Enter the disease, or shock, or heart failure. List of the control o	complications that caus	sed the death. Do no	254 Carre	o ll St., N dying, such as cardia	W, Washi	ngton, DC	20012 Approximate
Physic	ian		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on eacl Gangre	ne of Lef	t Lea				Interval Between Onset and Death
/Medi Examí	_		resulting in death)	Due to (or	as a consequence of	:				
		<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ridium difa as a consequence of		litis Seps	515		
P potned	[[a]	Examiner	that initiated events	C	Fibrilla					
8760, Cate be executed oblysician and	oula.	ial Ex	resulting in death) Last	Due to (or	as a consequence of)	:				
687	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Medic	IF FEMALE:	d						
vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certific r death. ector: After this certificate has been signed by the attending p	pen ioi palio	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown		h 2 Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specify			23d. Date of de Month	elivery Day Year
ds, P		2	Part II. Other significant conditio	ns contributing to deat	h but not resulting in t	ne underlying cause	given in Part I.		ebacco use contribute t	
aw requ		Completed					-	24a. Was a	an 24b. Were a	utopsy findings available
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed by the standard of the	of the state of th							autop perfor 1 □ Yes	med? death?	completion of cause of s 2 □ No
Vit vslcian s certif		20	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🔀 Inp	atient 2 □ FR/Outn	atient 3 DOA	041-	ath (Check only or	ne) ence 6 □Other (Spe	noite)
on of		ü	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of I			njury at Vork?		ow injury occurred	эспу)
isio ttendi death.		cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation of be	Injury - At home, farm	M	I □Yes 2 □No	28f Location /S	itreet and Number or F	Lucal Pauto Alumbar
Div tal or A s after al Direc		Certification: To	4 ☐ Homicide determi	building,	etc. (Specify)	, street, lactory, only	56	City or Tow	n, State)	urai Houte Number,
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he considered the property of the control	in a second	edical	(Check only 2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examination and/	death occurred at th or investigation, in n	e time, date and plac ny opinion, death occ	ce, and due to the curred at the time, of	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
/ O	3		29b. Signature and title of certifier	tha	MD	Do	ense number 2066416		29d. Date signed (Mon	
			30. Name and address of derson w Sujatha Ramas	seshan, M.I	of death (Item 23a) (T))., 9901 M	edical Ce	nter Driv	e, Rockvi	11e, MD 2	0850
Reg	Stat gistra	~	31. Date filed (Month, Day, Year)	2009 32. legi	strar's Signature	pares				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 404 PM KAYMOND CARL PETERSEN FEBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA If Under 1 Year | If Under 24 Hrs. HOWARD GENERAL COUNTY MOSTIME MOWARD Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Min 1 ☑ M 2 ☐ F Yrs. Director 047-22-4507 7-24-1929 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director Ellicott City MDHoward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9329 Joey Dr. 21042 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ marked other than Elementary/Secondary (0-12) Chemist Chemistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev Peter Petersen Karen Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 9329 Joey Dr., Ellicott City, MD 21042 Norma Petersen / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation :2-8-2009 Hanover, MD Fund ervice Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SHOCK HOVRS /Medical Examiner NENAL OUEASE STAGE END YEANS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of: physician and s the burial-transit Exami that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STROKE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After ty filled in by the funera 1 Natural 2 □ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 30 063242 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1)00 MAKWAY SVITE 200 NIRAV SHAH 31. Date filed (Month, Day, Year) 32. Redistra Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Eugene Rush 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince hevero Prince 6.004 If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours Min. 578-42-6747 75 Director 1933 Washington, DC Apri1 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ▼Yes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2909 N Street, SE 20019 United States items 23a must k Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status ı "natural", or items edical Examiner m Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √x No Specify. Specify: ð Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Biology Lab Technician the years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Samuel Rush Florida Curtis ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Sandra A. Rush - Wife 2909 N Street, SE Washington, DC 20019 Department of Heal Important: If Item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lee's Crematory Feb 10, 2009 Clinton, MD Mame and Address of Facility Stewart Funeral Home, Inc. 21. Six ature of Funeral Service Line 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ChoKing Physician from /Medical Due to (or as a resequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of): the burial attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28a. Date of Injury
(Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 Pending investigation 1 Natural while cating STEAK iours after death.

neral Director: Af
rilled in by the fur 1807 1 Ti Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2969 N STREETSE determined 4 ☐ Homicide None

or Vital Records, P.O. Box 68760,

e Funeral the Hospital

State Registrar

29a, Certifier (Check only one)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day, Year) 2009

WASHINGTON DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

3001

FEB 1 0 2009

State of Maryland / Department of Health and Mental Hygiene O O O

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. in action to confident and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

that the death certificate be executed eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760,

	for State Registrar		Cert	tificate of	Death		,	Reg. N	ZUUS	004	88
	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										eath
ian	Mae Peachy Robertson							/20		1928	M
cal ner	4a. Facility Name (If not institution, give street end number)			4b. City, Town,	or Location	of Death			c. County of Dea		
	Prince george's Hospital Cheverly Prince										
		je (In yrs. last bir	thday)_	If Under 1 Year	If Under		8. Date of Bir (Month, Da			rthplace (State or	Foreign
	578-46-7569 1□ M 2気F	82	Yrs.	Months Days	Hours	Min.	10/5/1			ountry) etna, VA	
	Usual Residence of Decedent	02			·		10/1/1	720	GIC	clia, VA	
	10a. State 10b. County	10c. City, Town	n or Loca	ation						10d. Inside City	
뎡	DC	Washin	etor	1						1x□Yes 2	≧ □ No
Director	10e. Street and Number	, ,,	0	10f. Zip Code				10g. C	itizen of What C	ountry?	
al	5025 Meade Street N.E.				2001	9		Uni	ted Stat	es	
Funeral	11. Marital Status 12. Was Decedent Armed Forces?		13. W	as Decedent of Yes, specify Cub	lispanic Or	rigin? (Spe			14. Race - Am Black, Whit	erican Indian,	
5	1 Never Married 2 Married 1 Yes, Give			Tes, specify out			rtiouri, ctc.,				
db	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			X	- Сроспу				Specify: B]	Lack	
Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	(Give k	ent's Usual Occu	durina mos	st of worki	na	16b.	Kind of Business	/Industry	
du	Elementary/Secondary (0-12) College (1-4or			O NOT use retire							
ខ្ល	7	<u> </u>	ouse	Servic	T		/=:		ivate		
Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle	, Maide	n Surname)		
ျ	Ben James Jefferson						t Hubb				
	19a. Informant's Name/Relationship (Type. Print)								or Town, State,		
	Sam L. Robertson / Husband								C. 20019		
	20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from State	20b. Place of cemeter	f Disposi ry, crema	ition (Name of atory or other pla	ce)	D	ate	20¢. I	Location - City or	r Town, State	
	4 □ Donation 5 □ Other (Specify)		-	emorial			2009			Maryland	<u> </u>
	21. Signature of Funeral Service Licensee		1			-			Homes, I		
	Fifth Course Molors 5538 Marlboro Pike Forestville, Maryland 20747										
	23a. Part 1/Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
	Immediate Cause (Final disease or condition CEREBRAL THROMBOSIS										ath
	resulting in death)	a consequence		10						l Hour	
	Sequentially list conditions b. ARTERIAL SCLOROSIS									20 Years	3
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. ARTERIAL SCIDIOSIS Due to (or as a consequence of):										
Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										S
	Due to (or as	a consequence	of):								
Medical	d										
Me	IF FEMALE:									l	
an/	23c. If yes, outcome	of pregnancy 2 ☐ Fetal death	3□	Ectopic pregnan	су				23d. Date of de Month	elivery Day Ye	ar
Completed by Physician/	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant a	at time of death	5 🗆	Other (specify)					Wiona	Day 10	u.
Ph	9 ☐ Unknown Part II. Other significant conditions contributing to death b	ust not requilting in	* +b =	darking souss si	un in Bort		230 Did 1	obacco	uca contributo t	to the cause of dea	ath?
þ	HYPERTENSIVE HEART DISEASE	out not resulting if	i uie uik	deriyirig cause gi	velilirait	1.					
ted	HIFERIENSIVE HEART DISEASE							res 4	2 140 3 7	Probably 4 Dun	KIIOWII
ldr.	OLD CEREBRAL INFARCTION						24a. Was auto	osy	prior to	utopsy findings av completion of cau	ailable use of
ပ်	25. Was case referred to medical 26. Place of Death (Check only one)									s 2√∏No	
Be (
	1 Yes 2 No Plospital: 1 Inpati		<u> </u>	3 □ DOA Ot	ner: 4□N	ursing Hor	me 5□ Resi	dence	6 ☐ Other (Spe	ecify)	
ü	27. Manner of Death 28a. Date of Inju 1 Natural 5 Pending (Month, Da	ury 28b. ⁻ a <i>y, Y</i> ea <i>r)</i> I	Time of njury	28c. Inju	ry at rk?	2	28d. Describe	how inj	ury occurred		
cati	2 Accident investigation				Yes 2]No					
T T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, el	jury - At home, fa lc. <i>(Sp</i> ec <i>ify)</i>	rm, stree	et, factory, office		2	28f. Location (City or To			tural Route Numbe	er,
Medical Certification: To											
ical	29a. Certifier 1 Certifying Physician: To the best (Check only 2 Medical Examiner: On the basis of the basis	of examination ar	e, death nd/or inve	occurred at the estigation, in my	ime, date a opinion, de	ind place, ath occurr	and due to the ed at the time,	date a	(s) and manner a nd place, and du	as stated. e to the cause(s)	
Med	one) and manner st	ateu.		29c. Licen	se number			29d. D	ate signed (Mon	th. Dav. Year)	
_	haus Umanih	-10 m	10							,,	
	The wind will will be	cel m	1		25618			2/	6/2009		
	30. Name and address of person who completed cause of	death (Item 23a) Hospital			er10	Mars	vland	207	84		
ate	Lewis Marshall MD 3001 31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	DI.	TAE OHE	стту,	Ligit	7 14114	207			
ate rar	FEB 1 0 2009 Server 1.	rar's Signature									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JUNE RIPPEON JANUARY 30,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖵 F 218-38-1338 86 July 3, Director 1922 England Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d Inside City Limits 10a. State 1 □Yes 2 □ No Director Maryland Frederick Frederick r than "natural", or items 23a or 28a-f: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. In proctant: If Item 27 is marked other than "natural", or items 23a or 2 amy injury or other traumatic event, the Medical Examinator rust be none. 10826 Hessong Bridge Road 21701 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X☐No Completed by Specify Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher & Registered Nurse Education/Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be M.A. Blackman Evelyn Booles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn P. Rippeon / Son 7485 Utica Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Blue Ridge Cemetery | 2/2/09 4 Donation 5 Dother (Specify, Thurmont, Maryland 21. Signature of Juneral Sevice License ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. Kutte 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 201 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate l performed 2 🗆 No 1 □Yes 2-1 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

| Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending investigation ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 a rra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, MD, 300 West 9th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Sabrina N. Rice 2009 January 1810 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | Winder 1 Year | W 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 41 Yrs. 217-02-6975 1967 **Director** Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Example; must be notified at 1X Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1021 Madison Ct. 21403 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, its Medical Exemities. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1∐Yes 21∑ No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 <u>Legislative Specialist</u> Legislative Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James E. Neal ၉ Karen Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Rice(Husband) 1021 Madison Ct. Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 2-3-09 Crownsville, Md. Windows Reverse of &cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee Jarry M. Leese MOC483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 days disease or condition resulting in death) MOITOR /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 XN 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → npatient 2 □ ER/Outpatient 3 □ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director: Al
filled in by the fu 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 12400 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chirt Peterson NID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04 2009 Registrar

DHMH 17 Rev 1/2001

3altimore,

P.O. Box 68760,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#8 per FH2/11/09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nathan J. ROSEN 10:10 P M 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day Gear) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 □ F 1939 Michigan Director Sept.-69 376-38-0041 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Potomac Directo Montgomery 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 20854 8618 Wild Olive Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting h and Mental Hygie 18. Mother's Name *(First, Middle, Maiden Surname)*Clara Hart 17. Father's Name (First, Middle, Last) Be Abraham Rosen ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. 8618 Wild Olive Drive, Potomac, MD Devora Rosen, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery | 02/04/09 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License Adelphi, MD 251 Garrell St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Hyperviscosity Syndrome **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4 Years Multiple Myeloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypercalcemia, Pancytopenia, Jaundice and Completed Hepatosplenomegaly 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 □ No 1 □ Yes 1 ☐ Yes After this certification, funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖔 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No e Hospital or Attendi 24 hours after death. e Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hosp within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

State

Registrar

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

omours, MD

29c. License number

D 36520

29d. Date signed (Month, Day, Year)

February 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Phoebe S. Reeves 10:40p ^M 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges St. Thomas More Hyattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 1 □ M 2 1 F 577-26-5983 91 DC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notifled at 1KTYes 2 □ No DC Director n/a Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 43 V Street 20001 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Teacher Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norbert Broughton Lavinia Hayes မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Riverside Drive, New York, NY Daryl Simonds / Son 10032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐ Removal from State 1/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure Disorder 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Ajit Kurup, 4922 LaSalle Road, Hyattsville, MD

32 Registrar's Signature

D0063681

2/4/2009

			1 - State of Ma	ryland / Depa <i>Cer</i>	rtment of H			giene 009	05493
	Physici	an	1. Decedent's Name (First, Middle, Last) BONNIE LEE REED				2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	Feb	10 2009 4c. County of Dea	3:40 AM
	- Admin		Genesis HealthCare - T	he Pines		aston		Tal	bot
	Funeral Director		531-48-0156 1 M 2 X F	(In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birtl (Month, Day 1 / 3 / 1 9		thplace (State or Foreign ountry) shington
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryl f sho	tor	MD Caroline	1	Federals	sburg			1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28a-f show r must be notifled at	Funeral Director	10e. Street and Number		10f. Zip Code	2.0		10g. Citizen of What C	
	s 23a nust t	erat	27286 Willin Lane 11 Marital Status 12. Was Decedent E	verinits 13 h	2163 Vas Decedent of H		pocify Ves or No.	United	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 N If Yes, Give Year or Dates:	o i	Yes, specify Cuba	Specify:	to Rican, etc.)	Black, Whi	
5-0	72 ho 'natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup kind of work done of OO NOT use retired	ation during most of wo	rking	16b. Kind of Business	/Industry
ed 2121	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+		GNA) -		William	Hill Manor
de de	il Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
ylar	Menta Menta arked artc ev	TO E	Sylvester Elmer Haynes			Esther	Irene	Huntingt	on
ni (d 2 shoth and 7 is mutanm		19a. Informant's Name/Relationship (Type. Print) Louis Reed/Spouse					alsburg,	
Bonn ore, Ma	f Healf tem 2 other		20a. Method of Disposition	20b. Place of Dispos cemetery, crem			Date	20c. Location - City or	
m P	Pages nent of I int: If ite		1 ☐ Burial 2 ☎ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	Mid Sho			1/09	Cambridg	e, MD
Bonnie Re- Baltimore, Maryland	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee Auxitum M. Cor	ele 22	Name and Addres	ss of Facility m Funer	al Home	PA Fede	ralsburg, ryland
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	larry.	Hemia				Onset and Death MFWWas
	Examiner		Due to (or as a	consequence of					
	D #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):			14/4		
}	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to or as a	consequence of):		-			
8760	icate be executed physician and s the burial-transit	dical E	d						
9	certificate Iding physi	Medi	IF FEMALE:						
Вох	that the death certifii ed by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	P ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.O.	the de	hysic	1 ☐ Yes 9 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ine or death 5	Tottler (specify)				
	w requires that the sbeen signed by the should be detached	by P	Part II. Other significant conditions contributing to death but				23e. Did to	bacco use contribute t	o the cause of death?
ord	requir een si hould I	ted	_ cometare state from to	rain stem, syndrome	rnjance is	1008	1 U Y	es 2XNo 3∏P	robably 4 Unknown
Vital Records,	The law te has b	Completed	Wolff-Vackinson-White	syndrome			24a. Was a autop perfor	sv prior to	utopsy findings available completion of cause of
ta	an: Th tificate or, pag		25. Was case referred to medical			26 Place of De	1 Yes	No 1 □Ye	s 2□No
, <u>;</u>	nysicia nis ceri direct	To Be	examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatier	t 2 ☐ ER/Outpatien	t 3□ DOA Othe			ence 6 Other (Spe	ecify)
O LO	ing Pl		27. Manner of Death 28a. Date of Injung (Month, Day	Year) 28b. Time of Injury	Worl	y at k?		ow injury occurred	
Division or	Attending Physician: r death. ector: After this certific by the funeral director,	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury	y - At home, farm, stre		Yes 2 □ No	28f. Location /S	treet and Number or F	ural Route Number
U. Y	al or / s after al Dire	Certification:	4 Homicide determined building, etc.	(Specify)			City or Tow	n, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of and manner state and	examination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	vithii To th	ž	29b. Signature and title of certifier	7	29c. License	number	3	29d. Date signed (Mon	
			July)	/ND	2	107/1		1.10-	.09
			30. Name and address of person who completed cause of de MICHALL ROWLEY	atn (Item 23a) (Type,)	DUTCHM	ANS LI	ANK /	EASTON M	.09 10 21601
	Sta			r's Signature	W			,	
	Regist	ar	LEG TT FOOD VALLE	1. 17					

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	Physici	an	1. Decedent's Name (First, Middle, La	ist)						Date of Death Month	Day	Year	3. Time of D	Death
	/Medic		Gloria Capretti						Ja	n. 23,	2009	1001	0625	М
	Examin	er	4a. Facility Name (If not institution, gi 107 Julian Ct.	ve street and nu	mber)		4b. City, Town,				4c. County	of Death		
É	Funeval			Sex	7. Age (In yrs	last hirthday)	Greenb If Under 1 Yea			Date of Birth	P.G.	O Diethe	lace (State or	Fomian
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	aryłar show d∎t	_	10a. State 10b. County			ity, Town or Lo	cation					1	0d. Inside City	
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	a or 3	Ρį	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	try?	
	leath	Funeral	107 Julian Ct.	12. Was Dece	edent Ever in U	LS. 13 V	20770 Vas Decedent of	Hispanic Orio	nin? (Specify	Ves or No.	U.S.A	ce - Americ	en Indian	
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ğ	ral", d	d by	3 X Widowed 4 ☐ Divorced	If Yes, Gir Year or D		1	∐Yes 2⊠No	Specify:			Specify	v: Whi	te	
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Modical Eventral rulet be notified at	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	lent's Usual Occi	upation e durina most	of working	1	6b. Kind of B	usiness/Ind	dustry	
121	vithin	<u>I</u>	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work don 00 NOT use retir nistrat:				II C	01-		
d 2	filed v Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Lasi)	·	Adill	mistrat.	1	r'e Name /Fir	et Middle M	U.S.			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventiant must be notified at once.	To Be	Frank Capretti	,						Mazzaf		16)		
ary	shoul ind M imari	F	19a. Informant's Name/Relationship	Type. Print)		19b. Mailin	g Address (Stree					State. Zin	Code)	
ž	alth a		Mark A. Schulstad	l, Sr./S	on		iller Ro						2000)	
Baltimore,	of He of Herm		20a. Method of Disposition	10	20b. I	Place of Dispos	sition (Name of natory or other pl	ace)	Date	2	0c. Location -	City or To	wn, State	
Ĕ	Page ment ant: It ury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont		State i		1n Crem		2/8/2	009 В	rentwo	od, M	D	
3alt	eparticoloristicolori		21. Signature of Funeral Service Lice	rsee	0	22.	Name and Add	ress of Facility	Ft. L	incoln	Funer	al Ho	me	
_	<u>₽</u> □ = 8 9		Alreane Ch.	Corp	Mar	34	01 Blad	ensburg	g Rd.,	Brent	wood,			
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that c one cause on e	aused the deat ach line.	th. Do not ente	er the mode of dy	ring, such as o	cardiac or res	spiratory arre	st,		Approximate Interval Betwee Onset and De	een
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pancı	reatic	Cancer							Onset and De	saun
	/Medical Examiner		rooding in dodsin)	Due to (or as a conseq	uence of):								
		er	Sequentially list conditions, b. Due to (or as a consequence of):											
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate clusters of the clu											
oʻ	an an irial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	ficate be executed physician and s the burial-transit	dical		d				·						
9	ertific ling p e as t	Mec	IF FEMALE:											
B 0	death certific e attending p d for use as	ian/	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗀 Feta	al déath 3 🗌	Ectopic pregnar	ісу				e of delive	ry Day Ye	ar
P.O. Box	0 0 0	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 ☐ Unkn	nant at time of o	death 5⊔	Other (specify)		_				,	
	signed by	y Ph	Part II. Other significant conditions	ontributing to de	eath but not res	ulting in the un	derlying cause g	ven in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of dea	ath?
rds	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	d by	Hypertension, Ty	pe 2 Di	abetes,	Corona	ary Arte	ry Dis	ease	1 ☐ Yes	21 ⊠ No	3 Proba	ably 4 ☐ Un	ıknown
ပ္တ	aw requir is been si 2 should I	Set	Peripheral Arter	ial Dise	ease					24a. Was an	24b. \	Nere autor	sy findings av	/ailable
Ě	sician: The law certificate has t rector, page 2 s	Completed								autopsy performe 1 □ Yes 2	ed?	orior to con death? I∐Yes	npletion of cau	ise of
Ita	sian: ertifica ctor, I	Be	25. Was case referred to medical examiner?	5=-				26. Place	1	eck only one)		i 🗀 tes	2 LINO	
Division of Vital Records,	thysic this co		1 Yes 2 ⊠ No	Hospital: 1 ☐ I	npatient 2	ER/Outpatient	3 □ DOA Ot	her: 4 □ Nur	sing Home	5 ₺ Residen	ce 6 □Oth	er <i>(Specify</i>	·)	
Ĕ	nding Physician: th. After this certifics funeral director, p	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury h, <i>Day, Year)</i>	28b. Time of Injury	28c. Inju Wo			Describe how	injury occurr	ed		
<u> </u>	death death stor: / the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6.☐ Could not b		of lainer At he]Yes 2□N						
2	lor A after Direc	Certification: To	4 ☐ Homicide determined	buildir	ng, etc. (Specif	y)	et, factory, office		281. L	ocation (Stre	et and Numb State)	er or Rural	Route Number	ΣΓ,
	spita spurs neral fillec		29a. Certifier 1 Certifying Pl	ysiclan: To the	best of my kno	wledge, death	occurred at the	time, date and	place, and o	due to the cau	use(s) and ma	nner as st	ated.	
	To the Hospital or Attending in within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examone)	niner: On the ba and mann	asis of examina	ation and/or inv	estigation, in my	opinion, deati	h occurred at	the time, dat	e and place, a	and due to	the cause(s)	
	Voithi Voithi Comp	ž	29b. Signature and title of certiller	0			29c. Licen	se number		290	d. Date signed	d (Month, E	Day, Year)	
		ĺ	· · · · · · · · · · · · · · · · · · ·	LID			D55	5559			Feb. 5	, 200	9	
	6		30. Name and address of person who				•							
	6		Thomas Maslen, M. 31. Date filed (Month, Day, Year)				ter Dr.	, Greer	nbelt,	MD 20	722			
	Stat Registra		FFR 1 0 2009	32. Re	8. pa	Ros								

		1 - State of Registrar		artment of Health and rtificate of Death		ne.2009 05495				
Phys	ician dical	1. Decedent's Name (First, Middle, Last) Milton Steinbaum			2. Date of Death	Day Year				
Exan	niner	4a. Facility Name (If not institution, give street and num. Southern Maryland Hospital 5. Social Security Number 6. Sex 7	ber) '. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Clinton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Prince George 9. Birthplace (State or Foreign				
Directo		115 - 24 - 2385	78 Yrs.	Months Days Hours Min.		930 New York				
BAITIMOTE, MATYIANG 21213-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluinar must be retified at	To Be Completed by Funeral Director	Maryland	es: Rorea 16a. Decec (Give life. L Admin 19b. Mailin 2211 F 20b. Place of Disposementary, crem King David Men	10f. Zip Code 20746 Nas Decedent of Hispanic Origin? (Singles, specify Cuban, Mexican, Puerto Pyes, specify Cuban, Mexican, Puerto Pyes, specify: Ident's Usual Occupation (work done during most of work done during most	USA pecify Yes or No- o Rican, etc.) king Edi ne (First, Middle, Maid twin ural Route Number, Cit itland, MD 20 Date 20c y 5 2009 Fall	ty or Town, State, Zip Code) 0746 Location - City or Town, State LS Church, VA				
ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	ıl	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or d	ras a consequence of): as a consequence of): as a consequence of): as a consequence of):	er the mode of dying, such as cardiac Light public Exal Difeable Ectopic pregnancy Other (specify)	or respiratory arrest,	Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year				
To the Hospital or Attending Physician: The law requires that the death certifully a thours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Ph	23e. Did tobacco use contribute to the cause given in Part I. 23e. Did tobacco use contribute to the cause of the cause								
To the Hospital c within 24 hours at To the Funeral D completely filled in	Medical Cer	29a. Certifier (Check only one) 1 Sertifying Physician: To the base and manner 29b. Signature and title of certifier	est of my knowledge, death is of examination and/or inv r stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)				
5 S Regis	tate trar	30. Name and address of person who completed cause of TARA SAGGAR, M, D. 31. Date filed (Month, Day, Year) SER 10 2009	of death (Item 23a) (Type, P	D0066719 4CKS DR #203	WALDOR	F,MD 20603				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 10:10a м Saffell Dorothy Μ. 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Renaissance Garden of Charlestown Catonville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 20, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 🔻 Days Min. Year 910 Washington, D.C Feb. 98 226-58-5480 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Beltsville Prince George 1 ☐ Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20705 4717 Cardinal Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Labor Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Flora Cole Bernard Ragan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 402 Harrison Cir. Locust Grove, VA 22508 Joanne Spohn/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/11/09 Columbia Gardens Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Murphy Funeral Home 4510 Wilson Blvd Arl., ¥2203 menne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rears Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

2

MD

7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantings must be notified at

within 72 hours after

d 2 should be filed within 7 in and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any injury or other traur

Baltimore, Maryland 21215-0036

burial-trar attending physician the ass for use the director, page 2 should has certificate Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifice

Completed

Be

Certification: To

Medical

filled in by the funeral

24 hours a

To the within 2 To the F

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknow ģ

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementio

and manner stated.

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident 3 Suicide

25. Was case referred to medical examiner?

5 Pending investigation 6 ☐ Could not be 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 □Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

1 ☐ Yes

address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Regi Maiden Choice In Catonsville Mr

State Registrar

			Please Type or Prin				_			
			1 - State of Ma		rtment of t	Health and Mental Hy <i>Death</i>	ygiene Reg. No.2 N N C	1 151.97		
H	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of D Month		3. Time of Death		
٠,	/Medic	al	Mabel McKittrick Stinner January 31, 2009 6							
1	Examin	er	4a. Facility Name (If not institution, give street and number) Care Center at Oak Crest Village 4b. City, Town, or Location of Death Parkville Baltimore							
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date of B	irth 9. B	rthplace (State or Foreign		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits		
	e Mary ia-f sh	ctor	Maryland Baltimore	Parkville				1 ☐ Yes 2 🛣 No		
	vith the	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?		
	eath v	Funeral	8800 Walther Blvd. Apt. 131		21234		USA o- 14. Race - Am	perican Indian		
30	after d , or item	y Fun	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No. If Yes, Give	0	Yes, specify Cub	Hispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.) Specify:	Black, Wh	te, etc.		
9	hours	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Deced	ent's Usual Occup	pation	16b. Kind of Business			
9500-61212	be filed within 72 hours after death with the Maryland tal hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar mast be notified at	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 2	`life. D	O NOT use retire	during most of working d)	Greenfield	•		
מ	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle				
Maryland	2 should I h and Men ris marke raumatic	ရ	Lucian Noah 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	n Address (Street	Irene Cl	nadwick	7:- ()		
	es 1 and 2 should be of Health and Mental item 27 is marked or other traumatic eve		Samuel Stinner/Husband		•	Blvd. Apt. 1310		, ,		
Baltimore,	es 1 a of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos			20c. Location - City o			
Ě	t. Pages tment of tant: If ite		4 □ Donation 5 □ Other (Specify)	Kalas Cre	matory	2/3/2009	Edgewater,	Maryland		
g	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22.	Name and Addre	ess of Facility George P. ons Island Rd. I	Kalas Funer Edgewater N	cal Home Maryland21031		
		27	23a. Pa 1. Enter the dise / e, or complic / ir ns that caused to shock, or heart failur. List only on / cause on each line					Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Preumon				Onset and Death		
	/Medical Examiner		resulting in death)	consequence of):			Hara A.			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):						
	executed n and al-transit	xamine	that initiated events	Abrillation	2					
ρΩ,	be exe	Ш	resulting in death) Last Due to (or as a	consequence of);						
08/PU	certificate be nding physicia se as the bur	edica	d							
×	atter for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 4 □ Pregnant at	Pi Fetal death 3 □	Ectopic pregnand Other (specify)	ey	23d. Date of do	elivery Day Year		
	t the d by the lached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 1 9 ☐ Unknown		Cutor (epoony) _					
as, i	requires that the death een signed by the atter nould be detached for u	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause giv		tobacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4 Unknown		
Kecords,	w requ	letec	tube.	riparests agripagia, gastrostomy						
_	ilclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed	- P MEY C			24a. Was auto perf 1 □ Yes	ormed?// death?	tutopsy findings available completion of cause of		
VITa	iclan; certific ector,	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death (Check only				
0	g Phys er this eral dii	n: 70	27. Manger of Death 28a. Date of Injury	t 2 ER/Outpatient 28b. Time of	3 ☐ DOA 28c. Inju	4 Nursing Home 5 Res	idence 6 Other (Sp how injury occurred	ecify)		
	endin sath. or: Aft he fun	atio	1 Natural 5 Pending (Month, Day, 2 Accident investigation	Year) Injury		k? Yes 2 □ No				
DIVISION	I or Att after de Directe d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office	28f. Location City or To	(Street and Number or F wn, State)	Rural Route Number,		
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; p	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state an	examination and/or inv	occurred at the ti estigation, in my o	me, date and place, and due to the opinion, death occurred at the time	e cause(s) and manner a , date and place, and du	as stated. e to the cause(s)		
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. Date signed (Mon	th, Day, Year)		
	X	100	Excha Dafon MO			785	1/3/09			
	の色		30. Name and address of person who completed cause of deal of the Complete Cause of deal of the Complete Cause of deal of the Complete Cause of the	ath (Item 23a) (Type, F		Parhville, MD 2	17.34			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	's Signature		1	The second second			
	Registra	ar	FEB 03 2009 Server	~ B. So	ald					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Wary			ficate of		, ,	-	2009	05498
	Physicia	an	1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic		Laura A.	Scaffidi					Februar	y 3	2009	8:59 P M
- 3	Examin	er	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death				
-			Renaissance Garde			(()	Silver fUnder 1 Year	Spring	T		Montgo	
	Funeral Director		5. Social Security Number 6. S 219–48–1426 Usual Residence of Decedent	ex 7. Age (In	yrs. last birtl		Ionder Frear Ionths Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day 09–20–1	Yea <i>r)</i> 914	9. Birth Cou Can	place (State or Foreign ntry) ada
	land ow		10a. State 10b. County	100	c. City, Town	or Locat	ion					10d. Inside City Limits
	Mary If sh	ţo										1 √2 Yes 2 □ No
	r 28a	irec	10e. Street and Number	corge b			10f. Zip Code		1	I0g. Citiz	en of What Cou	ntry?
	h with	alD	3205 Stanford St	reet			2078	33			USA	
	ems r.m.	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was	Decedent of F	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	1	4. Race - Ameri	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examir or must be notified anone.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give Year or Dates:		l _	lYes 2∭X No	Specify:	o riiodii, oto.,		Black, White, Specify: Wh	nite
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give kin	t's Usual Occup d of work done	during most of wor	kina	16b. Kin	nd of Business/In	dustry
121	vithin nne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO	NOT use retire	d)		T - 1 -	1 0	
7	iled v Hygie ther t	Co	17. Father's Name (First, Middle, Last)	4	pul	DIIC	health		ne (First, Middle, I		eral Gov	ernment
ano	the familiar sed or ceve	Be C	Fred	Stark				Hattie	ne (1 irot, Mildale, 1	vialuell		rshall
<u> </u>	should Me mark	ပ္	19a. Informant's Name/Relationship (Mailing A	ddress (Street		ıral Route Numbei	r City or		
M	nd 2 salth a		Stephen A. Whitma		- 1	_			Drive, Ow			,
re,	s 1 al		20a. Method of Disposition	20			on (Name of ory or other place				cation - City or To	
E	Page nent c nt: If iry or		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	nemovar nom state				i i	5-2009	Δ1 ₀₃	vandria	VΔ
alti	partin porta y inju		21. Signature of Funeral Service Licen		ссгор	22. N	ame and Addre	ss of Facility Ra	usch Fun	eral	Home.	P.A.
m	B a L B		Willean.	R. Wor					Lane, Owi			
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only	olications that caused the cone cause on each line.	death. Do no	ot enter t	he mode of dyir	ng, such as cardia	or respiratory arr	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition Stroke Onset and Death									
A.	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
H	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Adult Failure to Thrive Due to (or as a consequence of):									
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				7 . 1					
,	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c. Congesti Due to (or as a cor			allure					
68760,	rificate be executed ng physician and as the burial-transit	call		. d.								
68	tiffical ng phy as th	Medical		w-								
O. Box	ath ce attendii or use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown							23	ery Day Year	
σ.	ires that the de signed by the a 1 be detached f		Part II. Other significant conditions o	ontributing to death but not	resulting in t	the unde	rlving cause giv	en in Part I.	23e. Did tob	pacco us	e contribute to the	ne cause of death?
ords	w requires s been sign should be	ted by										oably 4 🗌 Unknown
Division of Vital Records,	Physician: The law this certificate has Eral director, page 2 sl	Completed							24a. Was ar autops perform	y ned?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
/ita	cian: ertific	Be (25. Was case referred to medical examiner?						th (Check only on	4		
) t	Physic this cal dire	၉ ု	1 ☐ Yes 2 🔽 No	Hospital: 1 Inpatient				4 IXI Nursing H	ome 5 Reside			y)
n c	ing f	io l	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	er) 28b. Tii Inj	ury	28c. Injur Worl		28d. Describe ho	w injury	occurred	
<u>si</u>	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be		At home farm			Yes 2□No	29f Location (Ca	voot a nd	Number or Dun	(Courte Number
<u>≤</u> .	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Sp	pecify)	11, 011 001,	idotor y, ombo		28f. Location (St. City or Town	, State)	Number of Auta	ir Houle Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p.		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my	knowledge,	death oc	curred at the tir	me, date and place	, and due to the c	ause(s)	and manner as s	stated.
	he Ho In 24 he Fu pletel	Medical	(Check only 2 Medical Exan	iner: On the basis of examend manner stated.	mination and	or invest	igation, in my o	pinion, death occu	irred at the time, d	ate and p	place, and due to	the cause(s)
	To t withi Com	ž	29b. Signature and title of certifier	li li			29c. Licens	e number	2	9d. Date	signed (Month,	Day, Year)
			Leven !	uthuma	Ma,	MI)	D 595	524		Febr	uary 4,	2009
0.1	1 12		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Prin	t)					
KV	N 10		Loveen J. Puthuma	na, M.D., 31	10 Gra	acefi	eld Rd	., Silver	Spring,	MD	20904	
	Stat Registra	-	31. Date filed (Month, Day, Year)	32. Registraris S		6	Marked	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George Kendle SLAYMAN Sr. Month Dav February 9, /Medical 2009 1530 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F Yrs. 84 **Director** 220-16-3725 Nov. 25, 1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Experience must be rectified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Smithsburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11813 Rainbow Avenue 21783 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1943–46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 à 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced white Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cabinet maker 0 Moller organ 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Be Guy Slayman Nannie Findlay Kendle 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Slayman - wife 11813 Rainbow Ave., Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 🚶 2/12/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Freder Palus disease or condition n al resulting in death) /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 2 Anterioscheriz Cer. hs Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page autopsy performed certificate anos Mortgoridin Vital 1 □Yes 2 ⊡No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ot this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 2/5/2009 24 hours after death. **Unknown**M investigation 1 ☐ Yes 2 ⊡•No Subject fell. 2 4 Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State) 17635 Valley Road filled in by determined 4 Homicide mall COLDED HAL Hospital 21740 641 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 018019 FEB 10, 2009 D0011246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H3+1 MILL IT MAKERSTOWN, MD 21740 DATTA 340 no 31. Date filed (Month, Day, Year) FEB 1 2 2009 State 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

7-88E

State of Maryland / Department of Health and Mental Hygiene 05500 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** аМ 31, Elizabeth Marie Januarv 2009 4:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 189-24-0779 80 Feb. 11, 1928 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Eventure is ust be rediffed at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 9425 Overlea Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Otto Loos Maria (Unobtainable) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laraine Henchal / Daughter 9318 Edgewood Court; Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 2/15/2009 Brentwood, MD 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the diseas shock or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a Cerebrovascular accident 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an autopsy performed 2 XNo 2 🛛 No Hypertension 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A

completely filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar

29b. Signature and title of certifier

MUBNEW

31. Date filed (Month, Day, Year)

FEB 05

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

- Zewdre MD

32. Registrar's Signature

ZEWDIE HD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

67593

9901 HEDICAL CENTER Drive, Rock VILLE MD

29d. Date signed (Month, Day, Year)